



WHAT WORKS? WHAT FAILS?



**Compendium of newsletters from the
Navrongo Community Health and
Family Planning Project**

2001–2004



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What works? What fails?

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Foreword

This compendium marks the completion of *What works? What fails?*, an 89-issue series documenting findings from the Navrongo Health Research Centre's Community Health and Family Planning Project (CHFP) in northern Ghana.

The CHFP was launched in 1994 as a pilot project and expanded in 1996 to a factorial experiment to test the demographic significance of health and family planning programmes in a rural setting. In 2000 the Government of Ghana adopted the preliminary findings of the CHFP, incorporating them into a national health policy. All 110 districts in the country have been requested to reorient health care using the Navrongo approach to community-based services.

In 2001 *What works? What fails?* was created to provide a mechanism for CHFP participants, service

workers, community leaders and members, and project staff to communicate their experiences and insights to District Health Management Teams throughout Ghana. The series is designed to assist Ghanaian health workers in adapting Navrongo service strategies to local circumstances and needs.

This volume serves as a mechanism to disseminate CHFP methods for districts in Ghana implementing the Community-based Health Planning and Services (CHPS) Initiative based on the CHFP model. Along with the focus of informing the Ghanaian health community, these newsletters also enable CHFP skills to be shared more broadly in Ghana and elsewhere around the world to show what has worked and what has failed in an experiment to make primary health care more accessible to rural people.

Acknowledgements

What works? What fails? has been launched to share with people in Ghana and elsewhere experience about what has worked and what has failed in making primary health care accessible to rural people. The series is the result of a decade of collaboration between members of the Kassena-Nankana community and scientists who planned and implemented The Navrongo Community Health and Family Planning Project (CHFP). The cooperation, participation, and advice of community members is documented in the notes of the series. Realisation of *What works? What fails?* also reflects the contribution of workers, supervisors, and managers of health care services in Ghana. Also, without the input of key contributors, the *What Works?* series would have failed: The Managing Editor of the series, Mr. Niagia Santuah, was its principal reporter. Melissa Hamilton, technical editor of the series, was responsible for copy editing, layout, and design. Dr. James F. Phillips, Ms. Rofina Asuru, Mr. Robert Alirigia, Dr. John E. Williams, Dr. Abraham Hodgson, and Dr. Samuel Kweku Enos all contributed multiple issues to the series. When the Navrongo Health Research Centre was

founded in 1991, Dr. Fred Binka was the architect of community involvement in its research activities. The scientific leadership of Dr. Fred Binka was crucial to planning the Navrongo Experiment, and his philosophy of research utilization was instrumental to developing strategies for disseminating CHFP findings. This publication was made possible through support provided by the Office of Population, Bureau for Global Programmes, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation for the creation of the Communications Unit. The CHFP planning process was supported by the Rockefeller Foundation and the Finnish International Development Agency. The Community Health Compound component of the CHFP has been supported by a grant of the Vanderbilt Foundation to the Population Council.

Acronymns

AAK	Abura-Asebu Kwamankese District	DfID	Department For International Development
ACNM	American College of Nurse-Midwives	DOTS	Directly-Observed short-course Therapy for Tuberculosis
ARI	Acute Respiratory Infection	DPHN	District Public Health Nurse
AVR	Anti-Retroviral	DSR	Development Through Self-Reliance, Inc.
BCG	Bacillus Calmette-Guerin (Tuberculosis) Vaccine	EPI	Expanded Program on Immunisation
CA	Cooperating Agency	FFP	Food for Peace
CBD	Community-Based Distribution	FGC	Female Genital Cutting
CDS	Community Decision System	FINNIDA	Finnish International Development Agency
CEDEP	Centre for the Development of People	FP	Family Planning
ChC	Community Health Committee	FS	Facilitative Supervision
CHC	Community Health Compound	GCE	General Certificate of Education
CHFP	Community Health and Family Planning Project	GDHS	Ghana Demographic and Health Survey
CHN	Community Health Nurse	GHS	Ghana Health Service
CHNTS	Community Health Nurse Training Schools	GIS	Geographic Information System
CHO	Community Health Officer	GNMC	The Ghana Nurses' and Midwives' Council
COP	Chief of Party	GPRS	Ghana's Poverty Reduction Strategy
CHPS	Community-based Health Planning and Services Initiative	GRMA	Ghana Registered Midwives Association
CHPS-TA	Community-based Health Planning and Services Technical Assistance Project	GoG	Government of Ghana
CPR	Cardiopulmonary Resuscitation	GSS	Ghana Statistical Service
CRS	Catholic Relief Services	HARI	Helping Individuals Achieve their Reproductive Intentions
CSM	Cerebro-Spinal Meningitis	HIPC	Heavily-Indebted Poor Countries
CTO	Cognizant Technical Officer	HPN	Health Population and Nutrition
DA	Demonstration District	HRDD	Human Resources Development Division
DZ	Demonstration Zone	HRU	Health Research Unit
DA	District Assembly	IC	Implementation Communities
DANIDA	Danish International Development Agency	IE&C	Information, Education, and Communication
DDHS	District Director of Health Services	IM	Infant Mortality
DHF	District Health Forum	INDEPTH	International Network for the Demographic Evaluation of Populations and Their Health
DG	Director General	IR	Intermediate Result
DDG	Deputy Director General	JHU-CCP	The Johns Hopkins University Center for Communications Programs
DHMT	District Health Management Team		
DISHOP	District Health Operations		

continued

JICA	Japanese International Cooperative Agency	QI	Quality Improvement
KND	Kassena-Nankana District	QMT	Quality Management Tool
KNDA	Kassena-Nankana District Administration	QSA	Qualitative System Appraisal
LGA	Local Government Administration	RCC	Regional CHPS Coordinators
LSS	Life Saving Skills	RFA	Request For Application
M&E	Monitoring and Evaluation	RHA	Regional Health Administration
MAP	Men as Partners	RH	Reproductive Health
MARG	Most at Risk Group	RHMT	Regional Health Management Team
MCH	Maternal and Child Health	RIPS	Regional Institute of Population Studies
MIS	Management Information Systems	RSM	Rapid Survey Method
MLA	Multi-level Analysis	RTI	Reproductive Tract Infection
MMR	Maternal Mortality Rate	RTU	Regional Training Unit
MOH	Ministry of Health	SDHMT	Sub-district Health Management Team
MOH/GHS	Ministry of Health/Ghana Health Service	SO	Strategic Objective
NDC	National Democratic Congress	SOAG	Software Operational Advisory Group
NDSS	Navrongo Demographic Surveillance System	SSCE	Senior School Certificate of Education
NGO	Non-Governmental Organisation	SSSCE	Senior Secondary School Certificate Examination
NHRC	Navrongo Health Research Centre	SWA	Sector Wide Approach
OJT	On-the-job training	TBA	Traditional Birth Attendant
OPD	Out-Patient Department	TEHIP	Tanzania Essential Health Intervention Project
OR	Operations Research	TRT	Training Resource Team
PC	Population Council	TTF	National CHPS Training Task Force
PCP	Programmatic Cooperative Agreement	UC	Unit Committees
PHC	Primary Health Care	UNAIDS	Joint United Nations Programme on HIV/AIDS
PI	Performance Improvement	USAID	United States Agency for International Development
PIA	Performance Improvement Approach	UNFPA	United Nations Population Fund
PMP	Performance Monitoring Plan	VCT	Voluntary Counseling and Testing
PPME	Policy, Planning, Monitoring, and Evaluation Division	VHW	Village Health Worker
PLWHA	People Living With HIV/AIDS	WARP	West Africa Regional Program
PMTCA	Prevention of mother to child transmission (of HIV/AIDS)	WHO	World Health Organization
PPAG	Planned Parenthood of Ghana	WIFA	Women in Fertility Age Group
PST	Pre-Service Training	WST	Whole Site Training
PVO	Private Voluntary Organization	YN	Yezura Nakwa
QA	Quality Assurance	YZ	Yezura Zenna

Project design

Volume 3, Number 7, 2003

BEFORE THE BEGINNING

It is a pleasure and a privilege to be able to talk with you and ask you a few questions based on your vast experience in the field of family planning (FP) and reproductive health. Since 1955 you have had a lifetime commitment of supporting FP and women's reproductive health. What keeps you motivated and optimistic about the future of Ghana and Africa?

Well, what keeps me motivated simply is the fact that the task is not done. That women are still dying; that many couples still do not have access to FP methods. Women are still dying in pregnancy and in childbirth. Lots and lots of women are still dying from unsafe abortion or from natural miscarriages.

When did you realise this?

Half a century ago! Before I completed my Medical studies in 1954 in the United Kingdom I took a degree in Physiology and I had the privilege to write a paper on Nutrition in the British Empire particularly in Africa. In researching for this paper, I found how far behind we were in nutrition in my country Ghana and in West Africa generally. So when I finished I went into Nutrition. It was then that I discovered for myself what rapid fertility contributed to childhood malnutrition in this country. The name Kwashiorkor which was given to a disease which resulted from protein calorie malnutrition signifies the health of the first child when the second child was about to be born. When I started this if I asked a woman, "your baby is suffering from kwashiorkor" she would probably say "no but I am not pregnant." Kwashiorkor to them was a syndrome of added children not from nutritional causes at all but probably from something else. So I started teaching my

Prof Frederick Sai, Presidential Advisor on Reproductive Health, HIV/AIDS of the Republic of Ghana, is one of the architects of the Community Health and Family Planning Project (CHFP). He has served as board member for several international organisations, including Family Health International, Family Care International, Population Action International, Population Council, and the International Planned Parenthood Federation. Sai discusses his work and the reproductive health field in "Before the Beginning" and "Sai's Insights."



"Why are more women in Africa dying in childbirth than in other parts of the world?" asks Professor Sai

patients who were mothers about how to prevent the next birth.

You had already started talking about FP!

Yes, but that was unusual. In those days we were not allowed by the government in power to talk about FP. The government's aim was to increase the population as rapidly as possible. But when the government moved and another came in some friends and I who had started thinking and talking about FP came together and formed the Planned Parenthood Association of Ghana (PPAG) which got affiliated to the International Planned Parenthood Federation (IPPF).

What was the immediate task of PPAG?

We quickly got the government to write a population paper for the country. Although the policy has not been implemented satisfactorily at least a sound basis had been laid. The Busia government (1969–1972) endorsed the policy but didn't give much attention to it. After the coup the military government that took over made some attempts to implement it and we tried as much as we could to help in that direction. But all this did not give the kind of strength that one would like to see from government.

What was the situation like in other parts of the world?

Very much the same like in Ghana. I had moved to the IPPF in London and from there I was able to see what was happening in the rest of the world. I saw Bangladesh and what the programme was doing there. I went to Thailand and I was part of the group that facilitated the first grant to the nongovernmental organisation (NGO) headed by Michai and which has done very well indeed. I saw programmes in Latin America which were also doing well. If you are interested in getting something done in your country nothing will motivate you better than to see in practice what you are thinking about or that what you are helping to do actually works somewhere in circumstances which are not too different from your own. Bangladesh and Pakistan which I saw were not more educated or better organised than Ghana. So there was no reason why if these things had worked well there they should not work in Ghana.

But soon you were back in Ghana, did you try testing some of the ideas you picked from abroad?

Oh yes we did. When we returned we started things like the Danfa project in the late 60s and 70s trying to make FP and reproductive health much more accessible to the client. That worked to an extent but I left the country again before the policy was finally implemented and I don't believe it attained its full potential.



In cosmopolitan centres worldwide, mothers and their children survive as a matter of course

Could we talk a little bit more about your work internationally?

When I was with IPPF then quite accidentally I was invited to join the World Bank. From there I was able to see how much comprehensive approaches to these things could work even better than one was thinking of. The development parameter which was necessary to get these things really to move properly came very much more to the forefront of my activities than they had been in the past. Even though in the past I had recognized, as everybody else, that education and the emancipation of women and their ability to control their own lives and their own resources held probably the number one key to their being able to practice FP properly and being able to have safe pregnancy and delivery.

Anytime you went abroad you always came back with something to try on the local front!

Well, to some extent yes. But this is how one has moved until Dr. Jim Phillips of the Population Council in New York discussed with me the possibility of his being involved in a demographic and health research activity in Ghana. The aim was to be able to get a proper serial or documentation of changes as they take place. Not only changes in terms of births and deaths, population growth but in terms of attitudes, in terms of practices and in terms of what the people would themselves want to see how they understood their own contribution to their own development.

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SAI'S INSIGHTS—SO FAR, HOW FAR?

You have had an impressive international career in the field of reproductive health. In what way has the International Conference on Population and Development (ICPD) benefited Africans generally and Ghanaians particularly?

The ICPD as we call it, was a remarkable conference to the extent that for the first time the word “development” was put as a heading to a population conference and it wasn't by accident. By the time we went to Cairo it had been accepted by everybody that population and development were two sides of the same coin and that one cannot progress without the other. What ICPD did was to put the population strategies and tactics well within development needs and approaches. It went beyond that and indicated that of all the development needs that would impact on population activities and be impacted by population activities were related to women and girls and that the education and change in status of women and girls is sine qua non for their being able to want to and to succeed in looking after their own fertility and general health.

It was a complete change of heart, wasn't it?

Very much so. It was what people have described as a “paradigm shift.” Instead of having specific programmes dealing with fertility regulation alone there was the need to have programmes which in the larger context deal with women's development and giving women power to negotiate their own life needs; helping women to understand what is needed and to be themselves involved in planning the activities that they want to see. It is only within this broad health agenda—from birth to death almost—for the women that we would be able to make a rapid and sustained impact in reproductive health generally and in FP and fertility regulation in particular. This, as a matter of fact, was an approach that suited African leaders very well.



From Cairo to Kayoro, women have shown increasing concern about being able to regulate their fertility

Why was it so?

African leaders were a little reluctant about the way people were talking about population that Africans were growing their children too rapidly; that African population was interfering with African development. It was so much in figures and figures that African leaders felt there was no humanness in it. The ICPD was able to make African leaders see that population and fertility regulation and infant mortality, child deaths and the deaths of mothers when they were going to have children, were all interrelated. It was then that they had the courage to talk about how to improve the lot of women, how to improve thereby the lot of their communities by including these specific activities which we call population activities in this grand thing. So they got courage to speak and many African countries and African leaders now have the courage since ICPD, to talk about these issues.

Well, there is still this idea of unmet demand for FP. What priorities should be pursued within the FP programme to meet this unmet need?

The unmet demand is based on women who are married, who probably do not want to have any more children but are not using any contraception. It also has to do with women who want to postpone the birth of the next child but are not having any contraception. Research has shown that if we go at programmes to meet what these

people need we don't even need to have demographic targets the population approaches would take care of themselves. So the first thing really is to make our programmes be able to find the types of women who do not want to have any more children, who want to postpone the birth of the next child and are not using any contraception. The other unmet demand is in fact, strange enough, that the people themselves do not even recognize it. This is in respect of adolescents. Just consider that in Ghana by the age of 20 about 90% of adolescent girls would already have had sex and practically all of this has been outside of marriage. The majority of these girls would tell you their first sexual contact and even their last sexual encounter was without contraception. They have a demand they haven't even recognized yet! So this is an area that we need to be very very sensitive to and focus attention on by developing programmes to help them through.

Have Heads of State, Heads of Government and cabinet members shown leadership and commitment in support of the FP programme in Ghana, for instance?

Yes, for sure. But let me start with Africa as a whole. In 1974 when we had the Bucharest Conference Africans were saying development is the best contraceptive, supporting India and other countries. By 1984 when we had the Mexico Conference African leaders had met in Arusha and had agreed that FP was to be an integral part of development. For the ICPD the African region had met in Gore in Dakar and actually came out with suggestions about what to do to cut down the fertility rate and bring down the population so that development can be accelerated. So within three conferences African leaders had already come to an understanding of what was needed to be done in these fields even if most of them are not doing it too well. In 1987 we launched the Safe Motherhood Initiative, brought to the attention of our leaders why our women are dying and why it is that more women in Africa are dying in childbirth than in other countries. This has really fired the imagination of many African leaders and many of them have bought into the fertility regulation and FP programmes as part also of saving children's lives.



Adolescent girls have reproductive health needs that have not been recognized

How about on the domestic front, has there been something to smile about?

In Ghana I can say the last government wanted to promote reproductive health but its methods were not particularly sensitive so the programmes did not move as aggressively as they might. In the last two years the programmes have had a major flip in the sense that the President has shown his own interest and commitment by appointing me as a Special Advisor on Reproductive Health and HIV/AIDS. The government has negotiated with the World Bank for support for the HIV/AIDS programme. The President has himself been to launch the Safe Motherhood Year Week and other activities. The President's wife happens to be a nurse midwife and she is particularly interested in these activities of saving the lives of women.

Has this translated into money from the budget?

I am not sure we have got as much as we would like to have. But in some of the fields we have external assistance from the World Bank, United Nations Population Fund (UNFPA), World Health Organisation (WHO), United States Agency for International Development (USAID), and Department for International Development (DFID), and other sources. So there is money that supports the small budget line for these activities to be going on. But I believe programme management and programme decentralization so that the programmes are owned by the communities is what will make us successful. Of course in the case of Safe

Motherhood there is a need for a backup hospital and equipment and training. With regard to training the corps of obstetrician-gynaecologists—which was very very small in the beginning and is now beginning to grow rapidly—they are producing another cadre that can man the outposts and look after the women so that between those who have nothing at all and the super specialists there are experts who would be able to take care of the women in addition to highly trained midwives. Good progress is being made.

Equally well in all programme areas, I suppose?

Actually, I have recently been worried a little bit about the lack of progress with FP. Because it looks like all these activities are going on and the lessons on FP are not being translated into action. That is why experiments like the old Danfa one and now the Navrongo Experiment come to show us how to go at making FP and Safe Motherhood activities a reality within the same programme.

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HEALTH FOR ALL IN SIGHT: THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

Introduction

It is a common claim that community health and FP programmes in sub-Saharan Africa are not working. Questions concerning “what to do” in response to evidence of programme implementation problems remain the subject of considerable discussion and debate. With international financial support, programmes have often been launched that have no guidance from scientific trials. For example, the “Bamako Initiative” has been launched to make health services conveniently available through village committees, health volunteers, and revolving accounts for sustaining the flow of drugs for Primary Health Care (PHC).¹ Also, Community-based Distribution (CBD) of contraceptives has been proposed as the best means of providing convenient low-

cost FP services. While these ideas are appealing, no systematic evidence exists to support the view that fertility and mortality can be reduced with these approaches. Does the Bamako approach work? Does CBD reduce fertility and ensure child survival? What is the best way forward for developing affordable and sustainable community health care? What should be the components of a community health system that works?

Health for all

In 1978, the World Health Organization convened the Alma Ata Conference to address similar concerns and to develop a consensus that “Health for All” could be achieved by the year 2000. Achieving “Health for All” through village-based PHC became the official goal of the Government of Ghana. Yet, by the early 1990s mounting evidence showed that Ministry of Health (MOH)PHC coverage for the country was low. Modern contraceptive uptake goals, particularly for FP, were not being met. Building health facilities at the village level (Level A) had never been part of the government’s strategies to decentralize health services. In any case, that would have been too expensive to sustain as a national programme. Community Health Nurses (CHNs) who had been trained for community work remained based in sub-district (Level B) clinics that were inaccessible to a large proportion of rural households. It was time to take health care services to the doorstep of the people and involve them in the design and implementation of health policies. Following this new thinking, a series of focus group studies was organized by the MOH to find out why health service utilization was low and why FP uptake specifically, was not progressing. Respondents

¹ The “Bamako Initiative” is the outcome of a UNICEF-sponsored regional health conference on sustainable primary health care delivery. It involves convening health committees at the village level, training health service volunteers, distributing primary health care drug kits, and operating a revolving fund for covering the cost of replenishing supplies as services are rendered. Three elements of the scheme are required to make it work: A logistics system for replenishing supplies; a financial system for managing the flow of resources; and a volunteer system for providing and supervising village-based health care.



Community Health and Family Planning Project (CHFP) staff and community members discussing ways of improving health service delivery in rural Ghana

appealed for health care strategies that, in the words of one woman, would “first make sure that our children do not die.” Child survival thus became crucial to the acceptance of FP. In addition to this precondition, respondents wanted service approaches that would respect their concerns about privacy. Women appealed for approaches that would put men at ease about FP.

Link to policy

The Navrongo Health Research Centre (NHRC) has a mandate from the MOH to investigate health problems of the Sahelian ecological belt of northern Ghana. The Centre was asked to take the next step beyond the focus group studies to develop a package of services that would respond to the expressed needs of the people and test the impact of this health development programme on fertility and child survival. Although there was unanimity on what needed to be done, there was no consensus on how to proceed. Some policymakers advocated retraining, reorienting, and relocating CHNs in ways that would make community health care a reality. Others were of the opinion that only volunteer services could be affordable and practical. Volunteer services, while representing an appealing concept, had, in the past, failed to produce satisfactory results. Debate about what to do with poorly functioning PHC village nurse and village volunteer strategies was at the core of

the view that an experiment was needed. By virtue of its research mandate and reputation, the NHRC was requested to carry out the experiment and Kassena-Nankana District became the site of this trial. The overall goal of the experiment was to improve coverage and quality of health care services. Specific questions were asked by the MOH that could not be resolved without evidence from a field trial:

- Is there a way to develop sustainable and effective volunteer components of the health care programme?
- Is there a way to mobilize CHNs so that they are truly community-based health care providers?
- Can CHN mobilization and volunteerism be developed jointly in ways that improve upon the effectiveness of deploying CHNs and volunteers separately?
- What are the costs and marginal benefits of each option?

Phase I: Consulting with communities about Community Health and Family Planning Project (CHFP) operations

The NHRC, with support and approval from the MOH, embarked on a series of consultations with the Chiefs and residents of the Kassena-Nankana District. The community members made constructive suggestions that helped in the design of the experiment that eventually became known as the CHFP or simply, *The Navrongo Experiment*. Discussions continued and services were changed and adapted to community opinion, reactions, and advice. In this way, concerns about promoting the survival of children, addressing the needs expressed by women for FP, and respecting concerns of men could guide the actual activities of the programme as it was developed in a micro pilot.

Phase II: An experimental trial

Over the initial 18 months of the project, services were launched in three pilot villages where community members served as consultants in the design and implementation of the service delivery scheme meant to



A woman expressing her views at a focus group discussion

respond to their expressed needs. The experimental trial was meant to seek answers to the following questions: was the design of the experiment appropriate? Will nurses agree to go to villages, live and work among the people? Will volunteers live up to their new tasks? How will community members respond to the new health service delivery? A great deal of care was taken to ensure that the ensuing design was culturally sensitive, appropriate, acceptable, affordable, and accessible. Once the overall system of culturally appropriate care was developed, the experiment went to scale in the entire Kassena-Nankana District in 1996. The reasoning was that community members had a fair idea about what would work and what would fail. The next challenge was to learn how to improve community health services and how to effectively deliver them as a package to communities and districts. Large-scale trial permits observation of the impact of a community-planned and culturally appropriate system of care.

Conclusion

Programmes launched with the aim of decentralising access to PHC in rural communities—where the majority of people in many parts of the world live—have been based on speculation. *The Navrongo Experiment* has been designed to test hypotheses that give scientific bases for such programmes. Numerous and varied lessons from the experiment attest to the feasibility of the project and

make the experiences worth sharing with others, not only in Ghana, but elsewhere around the world.

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PUTTING THE EXPERIMENT IN CONTEXT

Problem

Studies consistently demonstrate that passive clinical programmes based in district hospitals or sub-district health centres are not meeting demand for health and FP services. Instead, a truly community-based approach to PHC delivery is needed that addresses stated needs. One policy response in Ghana has been to develop policies supporting the creation of the community health and FP programme. However, the implementation of these policies is fraught with uncertainties and evidence that community health programmes can work is lacking. For example, while the placement of CHNs in sub-district clinics seems appropriate, the clinics are underutilised and the nurses sit idle because services are inaccessible to most households. Communities have systems of governance, social organization, and communication that are well known to politicians and widely used to mobilize votes or community action. These traditional organizational institutions have not been utilized effectively for the promotion and delivery of health care. In order to determine the best path towards developing affordable and sustainable community health care,



Typical compound in Kassena-Nankana District



Community Health Officer (CHO) providing services to community members

experimental studies must test the social and demographic impact of alternative programme strategies. A study located in Kassena-Nankana District of the Upper East Region of Ghana has addressed this need for experimental research.

Setting

The Kassena-Nankana District (KND) is one of 110 political administrative divisions, called districts, in Ghana. It shares borders with Burkina Faso in the north. Elsewhere, it is surrounded by five other districts. Latest demographic surveillance data put the current population of the District at close to 142,000, inhabiting 14,500 compounds that are unevenly spread over 1,675 square kilometres of semi-arid grassland. Residents of the District battle yearly with a rainy season from May to October and a dry season from November to April. Subsistence agriculture is the mainstay of the people, who are essentially rural dwellers with only 10 per cent urbanisation. KND has one of the highest illiteracy rates in the country with an illiteracy rate among females of six years and above reaching as high as 62 per cent. The CHFP has therefore been developed in the context of severe poverty and adversity. Titled *The Navrongo Experiment*, the CHFP examines policy questions with scientific tools developed for the evaluation of health technologies, permitting precise scientific appraisal of

ways to help people in significant need. Mortality levels in the CHFP study areas remain high while cultural traditions sustain high fertility. Traditions of marriage, kinship, and family building emphasize the economic and security value of large families. Health decisionmaking is strongly influenced by customary practices, traditional religion, and poverty.

Experimental design

In response to these circumstances, the NHRC launched a three-village pilot programme of social research and strategic planning in which community members were consulted about appropriate ways to organize, staff, and implement PHC and FP services. Community dialogue about pilot service delivery was used to design a system of village-based services that were compatible with the social system and sensitive to stated needs. Chiefs, elders, women's groups, and other community institutions were contacted by project workers and involved in a system of support for community health service delivery. Nurses, who in the past had been assigned to underutilized clinics, were reassigned to village-based CHCs constructed through communal labour for their use.

Four-cell experiment

An experimental design was developed during the pilot phase, in consultation with the three communities. Two



A durbar of Chiefs and community members discussing ways of improving community health

broad sets of resources were examined, each defining a dimension of the project:

- 1) The “MOH Dimension” reorients existing workers to community health care and assigns trained paramedics to village resident locations.
- 2) The “*Zurugelu* Dimension” mobilizes cultural resources of chieftaincy, social networks, village gatherings, volunteerism, and community support.

Since these dimensions can be mobilized independently, jointly, or not at all, the design implies a four-cell experiment. One cell each is reserved for experimenting with the “MOH Dimension” and the “*Zurugelu* Dimension” while a third cell has normal MOH services. The joint implementation cell tests the impact of mobilizing community-based health

care through traditional institutions with referral support and resident ambulatory care from MOH outreach nurses. Trial and error in the pilot phase developed service components of the full-scale experiment. In this phase, as before, community members served as consultants in designing service and mobilizing activities.

In 1996, a district-wide experimental programme was developed. Geographic zones corresponding to cells in the experimental design each represented alternative intensive, low-cost, and comprehensive service delivery operations. A demographic surveillance system, which monitors births, deaths, migration, and population relationships, is utilized for testing the impact of alternative strategies for community health services on fertility and mortality.

Planning the initiative

Volume 1, Number 3, 2001

ROLE OF RESEARCH IN *THE NAVRONGO EXPERIMENT*

Introduction

Launched in 1994 with the aim of finding ways of addressing the expressed health needs of rural Ghanaians, the Community Health and Family Planning Project (CHFP) or *The Navrongo Experiment*, is in line with Ministry of Health (MOH) policy guidelines for decentralising accessibility to Primary Health Care (PHC). Its ultimate aim is to test hypotheses about fertility and mortality reduction. The project design was based on the premise that existing idle human and material resources of the MOH can be mobilised in ways that improve accessibility, quality, and range of community health services. The project was also designed to test hypotheses about the health and family planning (FP) impact of mobilizing traditional leadership, social networks, and volunteerism for the promotion, delivery, and supervision of PHC.

Why Navrongo?

Navrongo is situated in the Kassena-Nankana District (KND) in northern Ghana. The district, with about 142,000 residents in 14,500 compounds, is an essentially agrarian traditional locality where mortality is high and fertility remained unchanged prior to project intervention. Baseline contraceptive use in the district was less than four (4) per cent and fertility about five (5) per cent. Immunization rates were low, and infant mortality was 120 per 1000 live births. Possibly as a consequence of high mortality, customs emphasising the importance of large family size deeply affect the social response to services, requiring careful strategic attention

in the design of reproductive health care. Survey results suggest that couples welcome FP services that emphasise childspacing, but qualitative research shows that many men fear that the introduction of FP and reproductive health care for women will diminish their status as heads of households. These are characteristics of a typical African rural community. Much is known about improvements in health status and survival that accompany economic development and social change; less is known about how to induce and sustain the health transition in the absence of economic development and social change. This is how KND became an ideal site for determining whether improvements in health can be attained and sustained in a traditional African setting using realistic interventions and resources without waiting for economic development or social change to occur first. The demanding features of the setting—the challenging context for developing health care and the



Navrongo Health and Research Centre (NHRC) had an elaborate research infrastructure to carry out the Community Health and Family Planning Project (CHFP)

daunting prospects for improving reproductive health care coverage—make Navrongo an ideal setting for community health research. If the health and FP needs of this locality can be met, then it is arguable that success is possible anywhere.

Although the setting makes *The Navrongo Experiment* an important policy initiative, research resources of the Navrongo Health Research Centre (NHRC) greatly expand the contribution of the experiment to policy. The core research resource of the NHRC is the district-wide Navrongo Demographic Surveillance System (NDSS) that records all vital events and ensures that the demographic impact of health services can be subjected to systematic trial. The NDSS defines household relationships, permitting the systematic storage and retrieval of information about individuals, compounds, or treatments over time for any special study in KND. The NDSS represents the relational structure for all other data sets collected at NHRC. A Panel Survey System (PSS) has also been instituted that monitors individual characteristics, preferences, and reproductive health status over time. Panel instruments record FP knowledge, contraceptive use, and intentions to use in the future. Shortly before the project was launched a sample of about 1,860 compounds was designated where all resident women ages 15–49 were interviewed in annual surveys about reproductive beliefs, motives, and preferences.

Research programme

Social research is conducted in conjunction with quantitative research systems. This qualitative research programme enables the project to get practical community advice on what works best and what does not work in this setting. Various features of the NHRC approach to research enhance the credibility of its results for policy: i) Results are based on the observation of a large population. Results cannot be dismissed as something that chance could produce; ii) Results are based on continuous population surveillance data that are free of recall biases. Standard procedures for checking on the completeness of the NDSS show that data quality is exceptional; iii) Multiple research systems' data and

research findings can be checked and cross-checked for consistency and reliability; iv) Most importantly, Navrongo research permits causal inference about what works and what fails. Longitudinal research, in conjunction with experimental designs, produces results that are not subject to challenge or alternative explanations.

Conclusion

The Navrongo Experiment has demonstrated, in an inauspicious social and economic environment, practical means for implementing Ghana's longstanding goal to develop community-based primary health care that works. Early results have challenged conventional wisdom about what works and what fails. The Navrongo research systems show that long-term observation is required and that overly simplistic investigation based on single-round surveys alone may lead to spurious conclusions and inappropriate policy advice since survey responses may not permit crosschecking and careful analysis. If the experiment succeeds—and impact measured so far suggests that it will—substantive project hypotheses will be supported; no Sahelian setting is fundamentally inhospitable to the introduction and success of community-based PHC care and FP. Establishing this insight requires the rigorous research systems that the NHRC has so comprehensively developed.



Testing the terrain before scale up

Frequently asked questions

- Cost**
- Q** The NHRC has equipment, facilities, and resources for research that most districts lack. How can a district possibly replicate the CHFP without access to these special resources?
- A** The NHRC always separates research operations from service delivery operations. All CHFP services are undertaken by the district health management team (DHMT) and use resources that are deliberately constrained to replicable levels.
- Contamination by research activities**
- Q** With so many research activities going on in KND, are the research activities changing communities in ways that bias results?
- A** The NDSS involves about 10 minutes of interviewing of every compound head in the district every 90 days. NDSS interviewing is not a significant intrusion into people's lives. The Panel Survey is conducted once a year in about 1,600 compounds. There is no evidence that panel responses differ from responses in households where there is less interviewing.
- Societal gains from research**
- Q** Research generates findings that scientists publish and disseminate. But, do the people of KND really benefit from research? Do they even know what the research is for and what has been learned?
- A** The CHFP consults with communities about research activities and explains the goals and purposes of studies before they are conducted. Dissemination of results includes community durbars on findings. Ways in which communities have benefited from the services associated with experimental studies are reviewed and discussed at the end of studies. In the case of the CHFP, which is a multi-year effort, this process of dialogue is continuous.
- Policy benefits from research**
- Q** Research costs money. How does the MOH benefit from this programme? Why not have a training and demonstration programme in Navrongo rather than a complicated research initiative?
- A** From the onset of the CHFP, activities have been guided by unanswered policy questions. Results are designed to produce evidence for decisionmaking. Evidence-based policy development saves resources by creating programmes that are efficient and effective. The national programme entitled the "Community-based Health Planning and Services Initiative" (CHPS) is a national effort to utilize results from The *Navrongo Experiment* for large-scale health programme reform.

Volume 2, Number 10, 2002

EVEN THE ANCESTORS WANT FAMILY PLANNING

The Kassena-Nankana of northern Ghana have no word for the supernatural; boundaries between reality and imagination do not exist. The gap between mortals and ancestral spirits is bridged by the medium of soothsaying. Every lineage is headed by a patriarch who practices religious rites for contacting spirits to explain events in the past, forecast the future, or guide decisions of current concern to families in the lineage. At the launching of the CHFP, it was expected that community members would consult the ancestors about the project. Since contraceptive use was uncommon in the Navrongo setting, it was assumed that ancestral consultation would lead men to reject FP. To explore this issue, social scientists from the NHRC compiled two matched interviews of male lineage heads. The first interview provided an indepth appraisal of the reproductive views and preferences of lineage heads. The second interview repeated these questions with the same individual through the medium of soothsaying, providing an appraisal of the views of ancestral spirits of nine lineages. Comparison of the responses permitted evaluation of the ancestors' role in FP decisionmaking.



Soothsayer preparing to meet the dead on behalf of the living

This investigation was based on the assumption that confronting spirits with fertility regulation, imported from abroad, and imposed without spiritual dialogue, risks cultural conflict and social imbalance. Ancestral spirits are believed to dwell on this earth through progeny. Services and themes of a FP programme may represent more of an affront to culture than a service to society. It is thus reasonable to expect people to fear alien ideas that risk social and spiritual disruptions. Under such circumstances, programmes will be rejected unless themes and messages are pursued in consultation with the ancestral spirits of the communities served.

To ensure salience and sustain interest, a questionnaire administered in the investigation was kept short and focused on reproductive health preferences. The questions used were:

1. Is it good for women in your lineage to have many children?
2. If you think about men in your lineage, do they have more children than they want, fewer children than they want, or just about the right number of children?
3. If you could start your family again, how many children would you have?

4. In this lineage, are big compounds better off than small compounds?
5. When babies are born in this lineage, is it better for a woman to have a boy or a girl?
6. Some men and women use methods to delay or avoid a pregnancy. In general, do you approve or disapprove of couples in this lineage using a method of FP?
7. A project has been launched in this village to provide men and women with health care and FP. Will this programme help your lineage in the future? Are there ways in which the programme is bad for your lineage?

Soothsaying sessions were dominated by ritual incantations for arousing the ancestors. Contrary to expectations that responses would be homogeneous, responses reflect considerable diversity of opinion, and often, the ancestors were more open to FP than the lineage head.

The following is typical of the responses to the question, **Is it good for women in your lineage to have many children?**

Lineage head: I would like each and every one of the women to have children, but I do not intend to let them have too many children, because it would be good to have the number of children that you would be able to take good care of.

Ancestor: The ancestors say that it is now difficult to get an education as well as to do farming. If a problem crops up, and the child is sick, then money is everything. You have to buy medicine, and even if you go to the herbalist, you need to take a fowl along for treatment. It is no longer the same as in the olden days, when everyone did farming.

Some even appear to be more concerned about the consequences of having many children than the lineage head:

Lineage head: I would like them to have many children because it is a large following that makes one a chief.



Ancestors are not shy about speaking through female soothsayers



Summoning the ancestors through ritual incantations

Ancestor: The ancestors would like them to have three children each. One would be your mother, one your father, and the other your child. (After probing:) They would like everybody to have a small number of children, but they should not refuse to have children altogether.

In fact, it was learned that while ancestors may have a role in a man's deliberations about the timing of childbearing, they are not consulted about preventing pregnancy. FP is something that is nontraditional, so tradition does not enter into decisions about it. As one young man stated:

It is left with you and your wife to come together into agreement before you go to see the person who will help you to practice the method. There is no libation pouring in this decision. You both have to understand each other before you go for the FP.

Numerous sociodemographic studies in sub-Saharan Africa have been directed to interviewing the living about their reproductive norms and aspirations. The Navrongo study was the first to involve respondents who are deceased. Findings suggest that religious practices are flexible and adaptive to social change. The cult of soothsaying is not emphatically pronatalist and should not be viewed as a social force that is fundamentally aligned against the FP programme. Organizers of FP programmes may encounter incidents whereby village events are interpreted by soothsayers, but the programme

itself will not be the subject of soothsayer-mediated spiritual review and consultation. The influence of traditional religion on reproductive behaviour is often characterized in the international social science literature as constraining reproductive change, as if African religious values are somehow anti-modern or are reactionary social influences which must be subverted if FP programmes are to succeed. Navrongo research shows that ancestors are far more accommodating to new ideas about reproduction and FP than conventional perspectives in the literature portray. Health and FP programmes can be developed in partnership with traditional religious leaders and in concert with traditional religious practices and precepts.

Volume 3, Number 6, 2003

HEALTH, THE PEOPLE'S CHOICE

Following are insights into the activities of the Village Health Committee written by Everest Dogenereba, a Health Committee member from Nayagnia Karamia community.

The Health Committee demands the full collaboration of the Health Aide, in order to achieve the desired results. A Health Committee member like a Health Aide is a trusted person who has been chosen by members of his or her community to voluntarily monitor the affairs of that community's Primary Health Care Services delivery, under the umbrella of the CHFP of the NHRC.

As a committed health service [provider], the Health Committee member does not work in isolation. He has to operate effectively alongside his fellow Health Committee members in the same community: the Health Aide, the elders, the resident nurse, opinion leaders and members of the community at large. It is this team spirit that brings the Health Committee into daily contact with the various categories of people already outlined. The Health Committee member works in harmony with a group of people, by holding regular meetings with them. The Health Committee member,

after holding a series of meetings with his counterparts, forges ahead to meet the Health Aide. At meetings, pertinent issues are uncovered and discussed exhaustively to find amicable solutions. The Health Aide [attends] meetings which afford both parties the opportunity to assess the strength and shortcomings of the health delivery system especially on the issue of drugs: drugs supplied to the Health Aide and sales, quantity available, cash in hand, type of drugs which in high demand. This is to avert the undesirable situation in which drugs have virtually run out, before the Health Committee member goes in [to collect] the next consignment of drugs. The Health Committee member must exert strict supervision on the Health Aide at all times.

In his trail of meetings, the Health Committee member does not lose sight of the elders and the community as a whole. He meets them separately at different times, according to his work plan. The Health Committee member first convenes a meeting with the elders to talk to about the need to construct a dwelling place for the community health officer (CHO). After discussing the pros and cons for such a venture, a general meeting is called for, through the elders, and in attendance will be all the Health Aides and the Health Committee members. As it can be observed from the outgoing episodic account of the nature of work the committed Health Committee member has to do daily, it must be admitted that this poor volunteer must be

operating on a comprehensive work schedule, which keeps him kicking day-in-day-out.

Apart from his meeting with the community and the elders and the Health Aides, collectively, the Health Committee member still has a duty to interact daily with members of his community, by reaching out to them in their respective homes to see how they are faring. These individual home visits afford the Health Committee member the opportunity to share his sentiments with them interact with them, and share their joys and sorrows. It also helps to put in place a dependable rapport, which goes a long way to enhance a workable relation between him and the community.

The Health Committee member having exhausted [ended] his rounds to individual homes calls a meeting during which he will make known his findings and draws the attention of the Health Aides to something they may have missed. These, among other things, include:

- Evidence of clean environment, as you move from house to house.
- How do community members dispose of their refuse?
- Are the surroundings weedy?
- What are the water sources available to community members?
- Is there a place of convenience? If yes, how far is it from the drinking water source?
- Are there stagnant pools around the houses?
- Do community members sleep under mosquito nets?
- Has there been an outbreak of any disease? If yes, was it reported to the Health Aide?

These questions constitute the agenda for a meeting between the Health Committee members and the Health Aides.

Having initiated a favorable comparison of findings with the Health Aide, it is up to the Health Committee to convene a meeting with the elders and confide in them about lapses on the part of some members of the community. He would report for instance, that some community members have failed to weed around their houses, thus their surroundings are choked with weeds to



Everest Dogenereba, Chair of the Nayagnia Karania Village Health Committee, on his farm



Mr. Dogenereba welcoming project staff to his home

the very walls of their homes. Pools of water could be seen everywhere. Others have defaulted in maintaining good health habits, as they do not apply all that the Health Committee, Health Aides and the resident nurse have been telling them. Although members have been told to wash fruits before eating them a good number of them eat shea fruits without washing them. Having reached an understanding with the Health Aide regarding the conditions in which the community members live, the Health Committee member informs the elders that community members are breaching the rules of personal hygiene and environmental sanitation and acting contrary to what the health volunteers and the CHO tell them. The elders on this account summon a meeting of all members of the community to meet the Health Committee, Health Aides and the resident nurse. This meeting helps address the shortcomings as witnessed by the Health Committee; the Health Committee member again has a crucial role to play at this meeting. At the meeting, the Health Committee recap their observations during their most recent house-to-house visit. Although the attention of the people would already have been drawn to those undesirable unhygienic situations, they ought to still remind the people to put a stop to such careless ways of doing things. The Health Committee member would not hesitate to tell them in no uncertain terms that we are all riding in the same boat and for that matter, an injury to one is injury to all. He would however end his speech by announcing to all and sundry that he anticipates a follow

up visit after the meeting and he would like to see a change for the better.

Now that the elders in attendance as well as the Health Aides and the resident nurse have been allowed to air out their views, all geared towards the same goal—clean environment—the Health Committee member takes the floor again, this time, to touch on more sentimental issues such as the six childhood killer diseases, STDs, the most dreaded of which is the HIV/AIDS menace. About the six childhood killer diseases, he reminds parents to immunize children against them to minimize infant mortality. He explains to members what STDs are, and solicits members' views about how these can be avoided. He tells them the best way to prevent STDs is to keep the slogan “Chastity before Marriage and Fidelity in marriage.” Those who engage in casual sex must always use a condom. He then goes on to exhort relatives of HIV/AIDS not to shun such victims. They should rather show them love and concern so that they would not consider themselves abandoned, even by their own close relatives.

Volume 3, Number 5, 2003

GATES WITHOUT COMPUTERS

Oscar Batabi Tiyyamo II is the 15th Paramount chief of the Kayoro Traditional area. He became chief in 1988 and is presently the Vice President of the Upper East Regional House of Chiefs. Following is a speech he presented at a durbar on November 2, 2002 before a team from The Bill and Melinda Gates Foundation who visited Kayoro to study, among others subjects, how the CHFP works.

The Director of the NHRC, Distinguished Ladies and Gentlemen, my elders and people of Kayoro, it is an honour and a great pleasure for me to welcome so many renowned personalities to Kayoro today. Kayoro is an isolated community, one of the most isolated communities in Ghana. It is far from all the big cities, the big industries, and the big people. It has no electric power; there are no vigorous economic activities going



Oscar Batabi Tiyiamo, Paramount Chief of the Kayoro Traditional Area

on. It is 25 kilometers away from the nearest health facility. But your visit to this community today is not by chance. Kayoro is an important community nevertheless, one of the smallest but most important communities in this country. Kayoro is the home of great things, the home of new ideas, the home of innovations. What has brought you all here today has to do with what Kayoro has done for Ghana, and for humanity.

Distinguished Ladies and Gentlemen, the goal of the new health promotion movement worldwide is for local communities to develop a process for enabling people to increase control over and to improve their health. This stems from the realization that, solving population health problems should no longer be the sole responsibility of health institutions. Community members and local groups must participate in open discussions and feel empowered to act on those health concerns that they jointly define.

A little less than 10 years ago a group of scientists plodded their way up here and together we started discussions that were to culminate in the discovery of improved ways of serving our people. The CHFP, now simply, The Navrongo Experiment, was consulting with communities to find appropriate means of improving health care delivery. It was the first time an experiment was launched here that considered ordinary people as consultants and active participants instead of passive

recipients of services. Our contribution was blunt and plain we needed services that would respect, not subvert, our rich cultural values. We said Kayoro is 25 kilometers away from the nearest health centre. We cannot get to the health facility it is the health facility which should come to us. Our advice was based on simple logic if our people can live in mud houses then health can also be located in mud houses.

Ladies and Gentlemen, for a moment, we ourselves thought we were crazy by suggesting that health care delivery could be provided from a mud house roofed with grass. We were even surprised to the point of being shocked to discover that the scientists were prepared to try out our ideas. Their reasoning was that community members were dependable consultants who had a fair idea about what would work and what would fail. We gleaned from our meager resources to build a community health compound (CHC), which you can see behind you, (points in direction of the CHC) where the nurse still lives and provides valuable and quality health services.

Before long the benefits of our innovative ideas began to show. Common diseases such as diarrhoea and measles reduced drastically. More and more of our children were surviving the difficult years of life. Fear-induced hatred of FP services started to fade away and our people began to discuss FP openly. Once success was



Kayoro is the most remote community in Kassena-Nankana District



Amy Knight and Alan Keller of the Gates Foundation are looking forward to building durable partnerships for global health promotion

recorded here in Kayoro the experiment was scaled up across the entire KND.

The rest is history.

Today health for all has become a reality.

Throughout Ghana community-based health service delivery is being organised using the Navrongo approach, which is based on ideas generated from this community. We feel justifiably proud that people like you come from far away across the ocean to see the birthplace of innovation in community-based health care provision.

Distinguished guests, on behalf of my people I wish to thank and congratulate the NHRC for being brave enough to have implemented our ideas and to assure them that Kayoro would remain a place of innovation and experimentation. A new CHC built with cement is springing up down there (*points in direction of the CHC*) to replace the previous one which is expensive to maintain. I believe the Director General (DG) of the Ghana Health Service (GHS) would continue to support the research institutions and communities to use the Navrongo approach to improve health service delivery in Ghana.

The Director of the NHRC, Distinguished Ladies and Gentlemen, my elders, and people of Kayoro, I hope members of the Bill and Melinda Gates Foundation would forgive our ignorance. The name Bill Gates is associated with computers. As you can see there are no lights in Kayoro. By implication there are no computers here. But I have been made to understand that the Gates

Foundation supports global health programmes. When our dynamic district director of health services (DDHS), Dr. Samuel Kweku Enos, used to tell us that he was a Gates Scholar, we did not understand. He has had the opportunity to study abroad under Gates support and his services are now available to us. What this means is that, even though we did not know who the Gates Foundation was and what it does, we had already begun to benefit from its generosity.

Distinguished Ladies and Gentlemen, it is our hope that if the Gates Foundation can continue to contribute resources we shall contribute innovative ideas so that together we can stamp out disease and make the world a better place for us all. We look forward to building durable and mutually beneficial partnerships.”

Volume 3, Numbers 11, 12, 19, 2003

HEALTH VOLUNTEERS AND VILLAGE HEALTH COMMITTEE MEMBERS: PERSONAL TESTIMONIES

Volunteers and village health committees for the CHFP work in various capacities to make health services accessible and affordable. Following are personal testimonies from volunteers and health committee members.

Health Cannot Wait

Agnes Aseyoro, health volunteer, Paga Boania
Malaria prevention and other health topics. The most important health challenge that I encounter during compound visits is malaria. I therefore turn my health education talks to malaria. First I try to demystify certain erroneous notions about the causes of malaria, such as sitting in the sun and eating raw mangoes. I make sure they understand that it is only mosquitoes that spread malaria. I explain to them how malaria is caused and methods of preventing or controlling the disease. I try to be as simple as possible. For instance I tell them that stagnant waters are good breeding grounds for



Agnes Aseyoro, health volunteer for Paga Boania

mosquitoes and these should be avoided. Where the pools exist and there is not much that be done about it, they must be sprayed to destroy the larvae. They should also sleep under treated mosquito nets at night to prevent mosquitoes from biting them. If they should take all these precautions and still get malaria attack, they must treat it immediately. I insist that the full course of the treatment must be taken in order for the drug to be able to destroy the parasites in the blood. Similar discussions are carried out for a number of diseases like cholera, dysentery, guinea worm, polio, measles, and cerebro-spinal meningitis. I also talk about the importance and benefits of FP and available methods of birth control.

Typical work day. The work of a health volunteer entails a lot. On a typical working day I wake up very early in the morning, sometimes without taking breakfast, in order to catch most of the people who are predominately seasonal farmers. I move out straight to the first compound preplanned for the day. The first person to contact on arrival is the landlord or landlady. After a short self-introduction and exchange of usual greetings and pleasantries with the residents, I state my mission. All this while I observe the compound with the

intention of talking about issues that are true to life. Under normal circumstances the rest of the family will be invited to join in the discussions. I commend them for every little effort they have made to keep the household environment clean. Then I proceed by adding what else needs to be done.

Administering treatment. At the end of the discussion, I find out if there is any sick person in the household so that I can give treatment based on the disease and its severity. If the situation is critical, I refer the patient to the community clinic or the hospital. After I administer treatment to a patient, I do a follow-up to find out how the patient is faring. If there is no improvement then I refer the patient to the hospital. In the absence of any thing I thank the people and then move to the next few houses. After visiting about seven houses I break for the day to continue the following day.

What it means to serve her community. The people's attitude towards me is highly commendable, perhaps it may be due to the value of services that I render to them. However, there are a few problems like the bicycle breaking down during compound visits. Sometimes I get beaten by the rain while trying to reach a sick person. All the same, even though it is voluntary work I enjoy doing it because I know service to God is service to mankind and I would never regret from serving God or mankind.

Kawia Baditera, health volunteer, Pungu-South

Though I enjoy the work it can be frustrating sometimes. Whether it is in the rainy or dry season it is difficult to get people to sit down to discuss health issues. During the rainy season people seek permission to go to their farms, if it is in the dry season they excuse themselves to go and tend their gardens. The people are so busy trying to make ends meet but as a health worker my duty is to convince them to sacrifice a little time to listen to my message because after all I am a health worker chosen by they themselves. As a woman, FP is very important to me. I tell them FP is about a couple being able to decide when they want to have children. It is also about spacing of birth, allowing one child to grow big enough to be able to carry the next child comfortably. I tell them about the benefits of a small

family size. The little food available goes round for a few instead of spreading it around for so many children. The woman remains healthy for a long time and the husband would not be motivated to go in for another wife. If a woman has only a few children they can all be looked after to grow up healthy and strong. All of them can also be well educated. In the long run this means peace, love and happiness for the whole family. I usually close for the day at about two o'clock in the afternoon.

Planning is key to the success of any economic activity. Before I go out to visit patients and clients, I first plan the number of compounds to visit, and prepare on some of the health education issues I might be talking on. Among the health issues I usually talk about are; FP, STD, especially HIV/AIDS, reproductive health, malaria prevention and management, prevention of cerebro-spinal meningitis (CSM), and cholera. I also assist the CHO during clinic days and home visits. I do referrals and keep records of my work and meetings with the health committee group and the nurse. I have become an opinion leader in the community. I now help to organize the community to undertake communal activities such as building of places of convenience, and wells for drinking water. I advise pregnant women to attend antenatal clinic, and encourage nursing mothers to practise exclusive breastfeeding.

Nyamekye Akaburi, health volunteer

I felt highly honoured and proud when I was called upon by the children and people of my area to serve them as a health volunteer. Although it is a voluntary job I did not hesitate to accept the voice of my people to serve them to the best of my ability. We work with the NHRC in community health service delivery. I was chosen by the chief in consultation with his elders, then introduced to the community who had the choice to accept or reject my nomination. I was unanimously accepted. You may ask, "What does the work of a health volunteer entail? What experience have I gathered over the years?"

Before I became a health volunteer, I went through a two-week long training workshop intended to prepare me adequately enough for the service. At the end of the training session I was re-introduced to the chief and the



Encouraging mothers to practise exclusive breastfeeding is just one of the many gratifying and worthwhile aspects of the health volunteer's job

community at a durbar organised by the chief. Delegates from the research centre attended the durbar which was a joyous occasion with a lot of drumming and dancing. Their duty was to present me to the community and outline the dos and don'ts of my job. I was to give drugs such as chloroquine, paracetamol, multivitamin, piritin, ORS, and condoms. I was not to give injections or antibiotics. The community was also to give me the needed cooperation to do my work. I was given a bicycle, a knapsack containing drugs, a notebook and a pen for records purposes. It was a great moment for me and a joyful occasion for all of us. After the durbar I got the moral backing of the community to start work which mainly consists of going round from house to house passing on information or educating people on basic health issues such as how to avoid the spread of diseases in the community.

The Board of Trustees

**Philemon Dise, Health Committee Secretary,
Paga-Kazugu**

The village health committee is a group made up of five people: Chairman, Secretary, Treasurer, Organiser and

Trustee. Its major responsibility is to oversee the health care system in the community. While a health volunteer must know how to read and write to be qualified to serve, health committee members, except the Secretary, do not have to be literate though literacy and numeracy skills are clearly an advantage at all levels.

The work of the health committee in Paga-Kazugu started on 24th November 1995. A health committee member is selected by his or her community based on commitment, integrity, and willingness to offer voluntary service to one's own people. The duty of the health committee is to help the community to have a better understanding of common diseases and how to prevent them. The health committee supervises the drug revolving fund by ensuring transparency and accountability in its management.

As a health committee member I contribute toward the elimination of common diseases in my community and district as a whole. This is good for me because it makes me gain more knowledge and experience and also respect among my colleagues.

At the village level, opportunities for public service are limited. Without education the situation becomes worse. We health committee members have reason to feel proud that we have been trained to be more useful to our communities than we could have been without that training. If indeed health is not for health professionals only, then we are privileged to be part of the nonprofessional health team that delivers health care to the most needy.

We are the link between health volunteers, the community and the project supervisors of NHRC. With the skills and training that we have, we are able to counsel people to know that not all diseases can be treated in their homes.

But we do not work in isolation nor do we feel too big to consult people. We work very closely with local political leaders such as the assembly members who are elected representatives of our community. In collaboration with the chief of our community, we call community meetings monthly to discuss issues and come out with suggested solutions or final decisions that are acceptable to all our people.

We work to promote more than just health issues. If the health volunteer runs into difficulties we are there to offer assistance. For this reason we often find ourselves having to help the volunteer financially when he is in dire need. On other occasions we have to organise communal labour to assist him do some farmwork. The response from the people on such occasions is always encouraging and this can be taken to mean they appreciate the volunteer's work.

So far we are satisfied with the volunteer because he works and seems to like his job very much. The only complaint is that the area he covers is too large and there is the need for additional hands to help out. The community members are happy because whenever trouble strikes, even in the night, there is someone nearby to turn to.

Health Committee Member, Paga Boania

A health committee member is someone who has been elected by his community to monitor the work of the health volunteer. They may be four or five in number. The health committee member makes sure that the health volunteer goes out daily to perform his normal duties. The health committee goes for drugs from the research centre to supply to the health volunteer, whenever he/she runs short of drugs.

Whenever drugs are brought, the health committee makes sure that the drugs are entered into the secretary's book. Whenever the health volunteer has collected any drugs from the treasurer, it is the duty of the secretary to enter it in his or her book. This is the reason why at least



A health committee at a review meeting



Health committee member replenishing drug supplies

the Secretary in a village health committee should be able to read and write.

It is the duty of the health committee chairman to call meetings and give reports. The health committee sees to it that the health volunteer's bicycle is well maintained and not misused by his friends or relations.

The health committee is to enlighten the people about good sanitation but sometimes members may also go round from house to house in the village. Whenever there is an immunization campaign or any health promotion programme, it is the duty of the health committee to inform the chief of the village to announce it to the people of the village to bring the children on the day given for the programme. Every month a designated health committee member goes and pays money on drugs sold and receives new stock.

John Asumkulba, Health Committee member, Vunania/Gaani

A health committee member's typical working day is a sweaty one. Early in the morning I wake up and say my morning prayers. Then I take the drug record book to check the balance to see which drugs are getting finished and how much cash is at hand so that I can go for more drugs. If I need to get some more drugs I note this on a paper. I quickly wash down and grab something to eat before I leave the house to start the day's work.

First I go to the clinic to greet the CHO and to find out whether she has any problems. If her compound is

untidy I organise people immediately to clean around the clinic. First I go to the chief's house, then to other health committee members and the health volunteer and inform them. Word is quickly spread around the community that some work needs to be done on the nurse's quarters.

Within minutes the clinic is swarmed by men and women with brooms and cutlasses ready to get to work. After taking part in the cleaning for a little while I excuse myself to go to the NHRC for a new stock of drugs. At the NHRC, I am usually received with courtesy. I pay for the old stock and receive new one. By the time I return the nurse's house would be well cleaned. Sometimes the community members take the initiative to get things done for the nurse without waiting for the health committee or the health volunteer to prompt them.

Whenever two or three are gathered the health committee member is always in their midst. In line with our duties, we talk to the people about health and health care. We advise them to keep their houses clean and that of their animals. I advise the young men to abstain from premarital sex, and those who cannot abstain should use condoms to prevent HIV/AIDS and other sexually transmitted diseases. I also advise them against female genital mutilation, which is common in some of our communities. At about sunset the health volunteer comes for his drugs though this does not happen everyday. I count the drugs for him and enter the information into the drugs balance book.

I encourage the health volunteers to let the health committee know what kind of problems they encounter in the field so that we can try to help solve them. It also enables us to tell others what kind of problems are associated with this kind of work.

Once Upon a Time...

Ms. Augustina Apuri, Yezura Zenna (YZ) for Paga Sakaa

Once upon a time, there was a village in the northern part of the KND known as Sakaa. This village never had access to orthodox medical treatment; they depended on herbal medicine for their health and

personal hygiene needs. Only a few kept their surroundings clean. This went on for a long time and the consequences were just unbearable many children died from preventable diseases such as cholera, malaria, and diarrhoea while others were paralyzed from poliomyelitis. We did not know the cause of these diseases and we did not also know they were preventable. The local herbalists always did their best but their best was never good enough. God smiled on the people of Sakaa when a health [research] institution in the KND known as the NHRC came into being in the 1990s.

The health research centre was concerned about health problems that attacked the people of the district, and tried to find ways of solving them. One day luck fell on my village when the health research centre came there and held a durbar with the chief, his elders, assembly members, opinion leaders, and the entire community to discuss health problems and how to solve them. They recommended to the chief and his elders to select one person so that the NHRC would train him or her in basic health care provision and come back to the community to treat minor health needs, as well as educate the people about personal hygiene and environmental sanitation. I was beside myself with astonishment when, at a meeting organized to select one person for the said training, my community settled on me. Some of the reasons that

were cited for choosing me were that I was honest, obedient, hard working, and prepared to work to promote the welfare of children. The community was also told I had the capacity to organize the community for communal labour and any voluntary work that was held in the village. They also said I could promote health programmes like disease outbreaks such as CSM and Cholera, which were very regular at that time. I was determined to succeed. I was presented to the NHRC for training. Villages around Sakaa both far and near also selected volunteers for training by the NHRC.

In all about eighteen volunteers were presented from the North Zone Communities and the training took place at the Paga Health Centre. We were taken through topics such as personal hygiene, the treatment of minor ailments, FP, sexually transmitted diseases, and several killer diseases. After I graduated from the health centre programme with my certificates, the NHRC organized another durbar in my community where they presented me to the community and spelt out what duties I was to perform and asked for cooperation among the people to enable me do my work effectively.

By the time I started work another group of people known as the Yezura Nakwa (YN or Health Committee) had been trained to monitor my work and help find solutions to the health problems of Sakaa. I was given a bicycle, a bag, notebooks to serve as my ledger and record books, a box of medicine [drugs] that was to be kept by my YN. I go for drugs anytime I need them. I now visit homes and give health talks on personal hygiene, and treat minor ailments I refer major cases to the clinic for further management. And today I am very happy that my people no longer depend just on herbal treatment. They now see the need to keep their environment clean, practice personal hygiene, participate in communal labour, and attend child welfare clinics. Disease outbreaks are rare and the people are prepared to fight any outbreaks in the community if they should occur. I work closely with the YN.

The group consists of five persons: a chairperson, secretary, treasurer, trustee, and one ordinary member.



Ms. Augustina Apuri, Yezura Zennu (YZ) for Paga Sakaa



The bicycle, a health volunteer's symbol of office

Meetings are organised regularly to solve health problems and I enjoy good working relations with the health committee. I can also say the YN is satisfied with my work. I am proud that, healthwise, I have been able to change my community for the better as a YZ.

Kaba Aviretiga, YZ for Wuru/Nawognia

A Yezura Zennu is a person with much patience who is selected by the community in collaboration with the NHRC. We are trained to move from house to house every morning with a bag behind us with the drugs inside to treat diseases like malaria, headaches, and stomach pains. I treat by giving my drugs to the person and showing him or her how to take them. The next day I go back and visit to know whether there is a change or not. If there is no improvement, I then refer the person to the community resident nurse for treatment. I also visit houses telling them about how to plan their family and how to prevent people from getting sick. Another thing I do is to advise pregnant women and nursing mothers to attend the prenatal and child welfare clinic, respectively, and on what day and time to go to the clinic. I always give the message to the elder in charge of the area to announce to the community about the day and time of the clinic. I help the nurse to run the child welfare clinics. I also visit the members of the health committee once a month for discussions and problem solving regarding the

community's behaviour towards health. If the problem is caused by me, the committee and the people of the community come together and try to solve it. That is how I have helped to bring health to the doorstep of the people in the Wuru/Nawognia community.

Sylvester Ajongyire, YZ for Giah

I was chosen by the chief and elders of the community of Gia to help deliver health service to my people. This work started in August 1996. Before then I went for a two-week training workshop organised by the NHRC. In that workshop I learnt many things. I was taught how to treat malaria and diarrhoea. I was also taught to recognize the signs, symptoms, and causes of malaria and diarrhoea. After the workshop, the NHRC organized a durbar and gave me a bicycle, a knapsack, and drugs at the durbar grounds. The health committee keeps the drugs in a box and issues them to the volunteers. When the drugs get finished, the YZ has to account for them and pays the money to the YN. In the morning I go out for compound visits, during which I give health talks, for example, on the prevention of malaria, diarrhoea, HIV/AIDS, and female genital mutilation.

The YZ helps the CHO. When there is an outreach, I usually inform the chief to cause an announcement to be made for the mothers to attend. In fact, I like the YZ job because it is very helpful for the community the drugs are very essential and affordable. I feel confident about myself because I am able to assist my community members to improve their health.

Volume 3, Number 15, 2003

A PIO'S OPINION: CHIANAPIO

You have been Paramount Chief long before the NHRC began. Has the NHRC had any impact on health in your paramountcy? Could you explain by giving examples?

VAST impact! The NHRC has been able to sensitise the people of this community on a host of health issues.

Through its activities, the people of Chiana are now exposed to several preventive measures against diseases. The health workers have also taught the people how to offer first aid to the sick and the need to vary their diets so as to gain the different nutrients responsible for healthy growth. But the people should not always be so helpless; they should learn on their own to avoid contracting diseases. This I think can go along way to reduce the burden on the health workers.

What diseases do you think have been brought under control if not completely eradicated?

The main ones I will say are fever and malaria. But there are a few cases of elephantiasis too. It is in the rainy season that malaria cases are mostly prevalent here because the mosquitoes tend to breed more due to the presence of stagnant water. However, the NHRC has provided treated mosquito nets for almost every household and this has helped in no small way to curb the alarming rates of malaria attacks and fatalities in the Chiana community.

Did anyone from the NHRC come to see you about the CHFP? Can you describe the first such occasion when someone from the NHRC came to talk to you about the CHFP?

I don't remember the exact date but it was somewhere in the dry season over ten years ago. Their first visit was to

talk about the Vitamin A Supplementation Project. In fact staff from the NHRC said they came to work with the people hence the need to familiarise themselves with the community to ease their work. Later on another occasion, the research workers came and said they wanted to bring a nurse to live with us and provide health care. They asked for accommodation in the community; my people did not hesitate to build some houses for them. I believe the nurses and my people are cooperating because I've not heard complaints from either side. We really appreciate the nurses' services and hope they will continue to do more.

What were your immediate impressions?

At first, we did not think things would work smoothly since we never experienced them, but all the same, we decided to give it a try. Soon we came to realise how important their services were to our existence. The health workers are hardworking because they leave early in the morning for their posts to work for the people. The NHRC nurses and the other health workers have also educated the people to report all cases of ill health immediately to the hospital or health centre for quick attention.

Some workers report that there is community apathy about the CHFP. Do you agree with this assertion?

What have you done to address such issues?

The people in this community are hardworking and they come out in numbers to help in the building and maintenance of the health compounds for the nurses. For instance, in Kanania and Nyangania we did not encounter any such problems in the construction of the CHC. The people in these places worked tirelessly to complete them. Women supplied water and men did the building. However, a little problem was how to store the water for use in Kanania, we were able to secure a water tank for construction work. We were happy when the first nurse was posted to Nyangania but, I'm sad to say, when she left there was no replacement for a long time and the people suffered a lot.



The Chianapio, Pe, Roland Adiali Ayagitam II



The Chianapio singles out the community health officer (CHO) for special commendation

Your sub-district has had a Health Centre since 1972. Did you really need a CHO in your paramountcy?

Over here, we have dispersed settlements quite unlike southern Ghana where the settlements are nucleated and clinics can be sited for one group of people at one particular point. Here our houses are too far apart and most of them are far away from the health centre thus getting a very sick person to the hospital becomes a difficult task. Nyangania, for instance, is about 7 miles away from the health centre in Chiana. Compounding the problem is that there are no ready vehicles to convey seriously sick people to the health centre. I see the intervention of these nurses as very crucial because they are able to move into remote places to render services to the rural people. The health centre alone cannot or will not do this.

A study has indicated that the ancestors are not averse to FP. As a traditional ruler, do you agree with this conclusion? Why do you agree or disagree with this conclusion?

I do not blame our ancestors for not planning their families because in those days there were no quality medicines and people especially children died easily and often. Infant morbidity and mortality were very high thus the need to give birth to many children with the hope that when death strikes, at least a few will remain. It was more like a reaction to some reality that could not be altered. I seriously support FP today because it is not easy to provide a large family with food, shelter, and

education for the children. Today, if you are not able to put your children in school there is the tendency that they will go wayward and may turn back to you for their needs even when they are grown up. This is a big problem for parents. FP is ideal because it makes you plan when to give birth and how many children to have. FP makes you able to plan your life and manage adversity and economic hardships that can deprive you of happiness all your life.

Volume 3, Number 16, 2003

OF PARAMOUNT IMPORTANCE: THE NAKONG CHIEF

Would you say the NHRC has had any impact on health in your paramountcy? If yes, could you explain by giving examples?

The work of the NHRC and its nurses has helped us here in the Nakong community a lot. For instance most of our children were always attacked by malaria but now, malaria has been drastically reduced and many more children now survive attacks. Measles has become a thing of the past. Women can also now deliver without complications because they get prenatal services from the nurse during their pregnancy.

Did anyone from the NHRC come to talk to you about the CHFP? Can you describe the first such occasion when someone from the NHRC came to talk to you about the CHFP?

Yes I remember but I cannot state the exact date. It is about 10 years or more. People from the NHRC came to discuss health issues with us. I and my elders and sub-chiefs received them well because it was a piece of welcome news. The people from the NHRC said they intended to place a nurse in our community so that we report our health problems to her for immediate attention.

What were your immediate impressions?

When someone comes from outside with an idea, you don't reject it. With regard to the NHRC, we knew

straight away that the work would be highly beneficial to us. We received them warmly and embraced their ideas. Nakong is an isolated community. It is also infested with the black fly and no one wants to come here. Even our own children run away. So we received them with open arms and prayed that the work would succeed.

Our nurses do complain that some members of the communities do not make efforts to help them in their work. They also complain some mothers even refuse to present their babies and children for check ups. Do you encounter any such occurrences?

Things of that sort do not occur in my community. On the contrary there have been occasions when nursing mothers and pregnant women will wait at an agreed time for the services of the nurse but she fails to turn up.

Your sub-district has had a Health Centre since 1972. Did you really need a CHO in your paramouncy?

Asunia, where the hospital is sited, is very far from Nakong. It is a journey of about 9 miles thus it is not easy for the sick to get there for treatment. There are no cars here to ease our transportation problems. There are times when one will wait from morning to evening without getting a car to Asunia. But with the nurse here, we need not go that far for treatment.



The Nakong Chief as he views the Community Health and Family Planning Project's (CHFP's) impressive results

What in particular has the nurse done that touches your heart?

The time and attention she gives to our children's health is what I *cherish most about her*. First when we were without a nurse, when our children fell sick during the night we became afraid that they are going to die because of the long journey between here and the nearest health centre in Chiana. Thanks to NHRC we now have a nurse who is doing a good job particularly for our children. But somehow I think that you have not been fair to us with the nurse. You see that Nakong is very far away. Why did you put the nurse in Katiu? After all, isn't Katiu closer to Chiana than we are? So I think this is an issue that you need to take up and place a nurse here for us.

A study has indicated that the ancestors are not averse to FP. As a traditional ruler, what can you say about this conclusion?

I think the ancestors are right and I strongly support their view. FP is now very crucial because more and more of our children are surviving and we can now know that when you have fewer children they can all survive. When we give birth to fewer children, you can take very good care of them. But in a poor and isolated community like Nakong, infant and maternal mortality are still of great concern.

Are there any aspects of health that you think have not been addressed under the CHFP? If yes, what do you think should be added to the programme?

Yes, indeed. We know that FP and reproductive health are important but for us here it is the black fly that is our biggest problem. Why don't you do something about it? The black fly has decimated our population. Many of the young men get blind before their fortieth birthday. As a result many of our children migrate mostly to the southern part of the country. You see that since you arrived you have been slapping your arms. If you were not wearing a pair of socks you would have been hitting your legs too. I am very old and it is a miracle that I can see you even as we talk. Most men my age have long



Women preparing shea butter as they wait for the arrival of their community health officer (CHO)

since gone blind. That is our plight and we think this should be of paramount importance to you too. In the night the mosquitoes take over. You gave us mosquito nets a long time ago that you wanted to test to see if they would prevent mosquito bites in order to reduce malaria. The nets have since got torn and we have not received new ones. We hear you have the nets for sale but they are not available here. If you give the nets to the nurse I am sure that many of our people will buy them.

What can you and your community do to support the NHRC in delivering health services to your people?

The thing we can do is to cooperate with you by facilitating your research work. We would encourage our people to embrace your workers and provide them with any information they seek whenever they come around. It is our hope that this way, your work would be less burdensome. We would, above all, patronize the services that are offered at our doorsteps. We shall make the nurse so busy that she would ask for another nurse to assist her. If you ever send us a nurse of our own we promise to glean from our meagre resources to provide her with decent accommodation.

Volume 3, Number 20, 2003

CENTRAL VIEWPOINT: NAVROPIO

We would like to know if you and your people have benefited in any way from the work of the NHRC. My subjects and I have benefited a lot from the research work of the NHRC. Since its inception over a decade ago, diseases like malaria, CSM, and many others have been brought under control if not completely eradicated. The NHRC has reduced the infant mortality and morbidity rates in the community. The women now deliver safely and their children grow up into healthy adults. I have noticed that the health research workers have been giving drugs and vaccines to pregnant women and children and this makes the children strong, healthy, and even intelligent.

Did anyone from the NHRC come to talk to you about the CHFP? If yes, can you describe the first such occasion when someone from the NHRC came to talk to you about the CHFP?

It is true that any time you want to undertake a new project you come to discuss with me. I always in turn let the information reach out to my people for them to know what you plan on doing. I was probably not available at the time you came to talk about the CHFP in particular. Your activities are so many that I will not



Arthur Wekem Balinia Adda—young, dynamic and in control of the Navrongo Traditional Area

even know which research project you're talking about at one particular time. Ever since you started working in my community, none of your workers came to lay a complaint that my people are making their work difficult—neither did any of my people complain that your workers are causing problems in the community. I thus think there has been cooperation and understanding between both sides. In fact the work of NHRC has won the admiration of my people.

I know some of our nurses are not working within the centre of Navrongo town but in the suburbs that fall under your jurisdiction. What is the importance of these nurses placed in the communities?

It is true that some of your nurses do not operate within the town but even with those in the villages, their work is without blemish. Just recently, I visited Gia and I was pleased with what I saw. A man fell seriously sick and was rushed to the nurse deployed there. But the nurse noticing that she had no logistics to face the situation quickly sped on her motorbike to town and brought a car to carry the man to the district hospital for treatment. This is something worthy of praise and emulation by others. The nearness of the nurse to the people is crucial.

Do health volunteers have any role in facilitating the work of the nurse in the community?

As you said earlier, these volunteers are not present in the town so I do not know specifically what they do. But talking about those people in the far off-villages, I think the NHRC alongside other authorities should strive to place vehicles in these villages so that emergency cases can be rushed to the big hospital for treatment.

Are there some diseases in the community that we are suppose to research into which we haven't done or which we are not aware of?

I will say NHRC has dealt with almost all the diseases I can think of. The few I think are polio and convulsion which use to strike our children but they have also been captured under your scope.

The NHRC involves all people in its work and so we consulted our ancestors through a diviner on the issue of FP and they condoned the idea. As the chief, what comments will you make on the stands taken by our ancestors?

We have noticed that those who accept and practise FP are those who have realized the difficulties involved in catering for many mouths. Today, farming is not as rewarding as in the days of our ancestors. It is woeful that some people are still living on the dark side of FP. They believe that God has given each person a number of children to deliver and so if you don't deliver the whole number given you and He comes to pick His share from the few, you will be losing. Meanwhile, others say God has asked them to multiply and fill the world so there is no need for planning family sizes. Being too gullible to these beliefs, people tend to forget the hardships that abound in today's world like cost of feeding, education, and the costs involved in getting medical attention. It's our duty to educate our colleagues to practise FP so that they too can enjoy its benefits.

Government has seen that the steps taken by NHRC are the most ultimate means of providing health services to the rural folk and is thus replicating its work in other districts. NHRC achieved this merit through you and your communities. How do you feel hearing this news?



At the durbar grounds: Even in the centre of things others often take the back seat

This is something that brings happiness to the people of the KND and the NHRC because it has been able to transform change to others. It is good that other districts take up similar projects so that at the end we will have a healthy Ghana and work to move the country forward.

Is there anything you would like to say regarding the work of NHRC that I have not asked you?

The relationship between my palace and NHRC is brotherly. If there is something that bothers us we can easily contact each other. I can remember sometime when NHRC visited Manyoro to start its work and mistakenly started dealing with someone who claimed to be the chief there but he was not the recognised chief. When I heard it, I quickly drew the attention of the Director and pointed out the dangers inherent in dealing with someone in the community in a capacity that he was not traditionally qualified to assume. The issue was speedily sorted out and since then I have not heard anything similar to it. Generally speaking the Navropio's Palace is satisfied with your work and my elders and subjects cherish your work very much. We hope things will continue and even improve.

Volume 4, Number 2, 2004

BRINGING CAIRO TO KAYORO: KAYORO CHIEF

You have been Paramount Chief here since 1988, just at about the same time that the NHRC started. Has the NHRC had any impact on health in your paramouncy? Could you explain by giving examples? Before the intervention of the NHRC, there were many diseases for which we could not find the appropriate medicine to cure. The NHRC has helped to eradicate most of these diseases—especially those that bother our children like convulsion. It has also addressed fever and malaria cases in my community. The Centre has provided us with insecticide-treated mosquito nets over the years and this has helped in no small way to quell malaria. Whooping cough is now also under control.

Did anyone from the NHRC come to talk to you about the CHFP? Can you describe the first such occasion when someone from the NHRC came to talk to you about the CHFP?

It seems so long ago to me to recollect things word for word.

In general, what was discussed at that time, and what were your immediate impressions?

They said that they were coming to help us improve our health—by providing us with health services from house to house, checking and investigating diseases, ensuring safe delivery, and monitoring children's health. We initially thought the NHRC came to work only on children but as time went on, its services widened to include adolescents, pregnant women, and finally the entire community.

Some workers report that there is community apathy about the CHFP. Does this happen in your community? What have you done to address such issues?

There exists cordial relations between the community and the nurse and they come out in numbers to work for the nurse—especially when it comes to maintaining her compound and giving her other related support. However, when people are busy with their own work such as farming, it is not always easy to organize them to do any other work. This is often an unfortunate situation



Not even drumming and dancing can distract a chief from thinking about the health of his people

but that is what happens when people are reduced to a choice between survival and health. You need to understand that the farming season here is just once in a year, unlike in southern Ghana where people farm all year round. In spite of this, when things are critical, I always send for the elders and talk to them to select people to come and get some work done for the nurse and it is usually done.

You remarked that there has been control over several diseases especially those affecting children. Are there any aspects of health that you think have not been addressed under the CHFP? What do you think should be added to the programme?

The work of the nurse has been really good but what is missing is to give her an adequate supply of drugs. There have been times that people go to her for medicine and she does not have it because she has run short. If drugs are made available at her post, it will help us a lot. She also needs to store vaccines and drugs for treating snakebites—a common occurrence here during certain times of the year.

You know the sub-District Health Centre in Chiana caters to all of you and has been operating for over 30 years now. Why should you need nurses?

The Health Centre is very far from Kayoro. If someone is sick here, we have to carry the person on a bicycle or a

donkey cart and this worsens the plight of the patient. The help given us by the nurse is therefore very enormous. We report all health matters to her at first for immediate attention so that by the time it gets worse, we might have been able to reach Chiana or the district hospital. This is the more reason why our nurse must not fall short of drugs.

A study has indicated that the ancestors are not averse to FP. As a traditional ruler, do you agree with this conclusion? Why do you agree or disagree with this conclusion?

FP is very good for us today because of the economic hardships and scarcity of food. In those days, our ancestors had very fertile farmlands and they really harvested the benefits of their sweat but what happens today? We farm on the same piece of land and we get little or no harvest at all. The soil is exhausted. Planning our families will therefore enable us to take good care of our children since FP guides us as to when to give birth and how many children to have.

The results of the CHFP have been used to develop a national health policy to be implemented across the entire country. The CHFP has equally caught the attention of the international community. Generally, how do you feel about your contribution towards this development?

The credit goes to the originators of the CHFP, that is, the NHRC and the KND as a whole. We do not emulate bad examples but rather examples that are beneficial and this bestows a good name on the originator of the particular work. But we can also share the glory of what has been achieved—it is well deserved.

What can you and your people do to enhance the work of the NHRC?

What we can do is readily embrace and support any new project or idea that the Research Centre brings to us. Another thing we can do is ensure that the facility being put up to assist in health work will be watched over and maintained by our own people.



With a corps of diligent volunteers in place to assist the nurse, health care delivery can be sustained at the community level

What's that structure all about?

What you are seeing is a new community health compound for the nurse. It is a joint project by the people of Kayoro, the DHMT—which includes the NHRC, the KND Assembly and the Vanderbilt Family in the US. It is a *zurugelu* project.

What else can you do for the nurse to make her happy to stay here and do her work effectively?

We are ready to help her if she chooses to farm. We can give her a piece of land and also assist with labour. We are willing to support her ideas which she thinks can help her do her work much better.

Volume 4, Number 7, 2004

WHAT'S ON A SOOTHSAYER'S MIND?

Contrary to long-held beliefs, the Soothsayer who may also double as diviner, sorcerer or healer, can play a crucial role in health care delivery. As the CHFP scales up across the district under CHPS, can the integration of the Soothsayer into the system be explored to improve emergency obstetric care?
Abing-ya Atasige, a renowned Soothsayer discusses his work.

Good morning sir. We are interested in learning more about your work so we are here to witness a typical soothsaying session and ask a few questions. What would you say is your profession?

I am a soothsayer.

As a soothsayer, what do you do?

I unravel mysteries, predict the future and solve people's problems.

What issues generally bring people here?

All manner of issues ranging from health, social, economic and political. The oracle may be asked to explain a calamity or mishap or predict the future of a person or event.

How much do you charge for consultation?

Nothing. It's free. Soothsaying is service to humanity. The client offers what he or she can afford.

What do people normally bring along when coming to consult?

It could be chicken, millet or money.

Is there any similarity between a sick person who seeks medical attention at the hospital and another who consults the Soothsayer?

In both cases there are procedures to follow—at the soothsayer's you have to come and “greet” before you consult the diviner. At the hospital you first obtain a card before you see the medical doctor.

What do you think is the main difference between the two?

Through the hospital system people can become rich. I don't know of anyone who became rich as a soothsayer. You may be given some gifts for helping to solve someone's problem but that is once in a long while. At the hospital you may have to pay before a service is rendered, at the Soothsayer's you get what you want first before the issue about payment comes up.



Abing-ya Atasige is not looking forward to handing over the trade to his child



A soothsayer's humble abode

Have you ever attended hospital?

No, never.

Have you never been taken ill before?

I have fallen ill but I have never attended the hospital. The trade I ply serves my purposes so I have never had to attend hospital.

Would you rather a sick person attends the hospital or comes to consult you?

It does not really matter—if a person falls sick and attends hospital and does not get the desired relief the person can come to me. On the other hand, if the person consults me first and has not been cured he or she can continue at the hospital and may get the needed treatment.

Is the hospital a major threat to the survival of your trade?

Not at all. They complement, not contradict one another.

What happens when someone comes to consult but has nothing to offer?

After consultation you just walk away! It is as simple as that. But usually what ever you have, you put it down first before consultation begins.

Does that not expose the system to corruption?

Suppose someone offers 2000 and another offers 10,000 cedis. Won't the oracle be more favourably disposed towards the one who offers more?

No. It does not work like that. It is not a cash and carry system. The oracle knows it is all about service to humanity and everyone offers what he or she can afford. As long as it comes from your heart, whatever you offer is acceptable.

What is the most ideal time for consultation?

Consultation is on first-come-first-served basis so it has become usual for people to come here at dawn with the purpose of avoiding a long queue which may start to build up by sunrise. But in principle the oracle is on call 24 hours a day.

Has there been an instance when someone brought a problem that was bigger than the oracle could handle?

Yes, that happens. In that case the person will have to decide where to turn to next.

Can the oracle go out of its way to refer a case to some particular specialist?

Yes it happens. The oracle can direct that a particular problem may be better handled at such and such a place so you should try your luck there.

Has the oracle ever referred someone to the hospital?

Yes. The oracle can say this disease can only be treated at the hospital so seek treatment there. That happens.

How long does a typical soothsaying session last?

It all depends on the nature of the problem for which consultation is being sought. If you are able to state your case clearly and fast, diagnosis is quick and before long your prescriptions are ready.

What would you say is your first line drug for malaria?

Well, that is common knowledge: boil Nim tree leaves for the patient to bath and drink. You may also use the bitter water to prepare vegetable soup for the person.

How about measles?

Measles has been a particularly bad disease. We usually recommend immediate immunization for the other children.

How is the immunization done?

You count the number of children in the compound and you give that number of groundnut seeds to the measles patient. He closes the seeds tightly in his or her palm until the seeds become wet with the sweat then you offer a seed each to the other children to chew and swallow. They would get an attack, usually a mild one. Then they would develop a resistance.

Do you still do it now?

No, we don't. I think measles has been wiped out now.

Do you think there would come a time soothsayers will be rare to find?

Yes that is possible but it will take a long time. People still come to us after medical science has failed them and they get the desired relief.

Would you be kind enough to train me to become a Soothsayer?

No. It's a difficult but thankless job. In any case, no one trains to become a soothsayer—it's an oracle's call.

Community entry and involvement

Volume 1, Number 7, 2001

SWIMMING AGAINST THE TIDE

The call for “community participation” to solve problems is far from unique. Nevertheless, examples and techniques for achieving this in practical terms are uncommon. The Navrongo Health Research Centre’s (NHRC) health and family planning (FP) initiatives confront a challenging context; significant institutional, economic, social, health and environmental concerns of community members must be addressed if programmatic efforts are to succeed. In keeping with the central import of community participation, the NHRC, from the outset, initiated an assessment of obstacles to programme creation in response to these constraints. Through qualitative studies on fertility norms, behavior, and beliefs, the advice of community members was used to identify and catalogue specific operational constraints and to provide culturally appropriate response strategies to them. The following were identified early in the Phase I pilot programme.



Community durbar

Environmental constraints

Settlement patterns. The population of Kassena-Nankana is both isolated and dispersed. Clinics are underutilized and public transportation is poor; consequently, community health nurses (CHNs) were installed and provided with motorbikes. Community leaders recommended that the bases of operation of CHN could be relocated effectively if assisted by the Chiefs and a community liaison officer. By charging communities with the construction of compounds for the CHN, the project elicited their involvement and support.

Seasonality. Fertility, mortality, and general adversity vary with the seasons in these agrarian communities. Strategic planning calls for a focus on FP in durbars during peak conception periods, a focus in wet seasons, etc. Further, FP service hours, cost, and location must be flexible and vary with the harvest season dry seasons.¹

Sociocultural constraints

The role of tradition. In this traditional rural society, the strength of central bureaucracy is surmounted by strong community leadership by Chiefs and Councils of Elders. Traditional leaders, then, must be consulted and involved in programme planning, and local institutions must be employed. For example, the programme can benefit from the *Zurugelu* system of traditional action committees and community durbars, which are usually

¹ Research has shown that fertility in the Kassena-Nankana District (KND) is highly seasonal. The period immediately following the harvest is the peak conception season. Appiah-Yeboah Shirley et al. 2001. “Impact of Agricultural Adversity on Fertility among the Kassena-Nankana of Northern Ghana.”

scheduled on market days for maximum attendance and impact.

Gender roles. In the discussions during village durbars, men demonstrated little understanding of, and interest in, FP. Married men often are apprehensive about this outside influence on reproductive behavior. Women's access to contraceptives is limited as they may be forbidden to travel for services or may lack reproductive autonomy. An assurance of confidentiality as well as open discussions, as in durbars, may increase information about, acceptance of, and trust in FP services. Men can be targeted through a *Zurugelu* programme for Chiefs, elders, and husbands while women may benefit from information, education, and communication (IE&C) activities addressing appropriate responses to husbands and kin who do not support contraceptive use.

Religion and pronatalist traditions. Soothsayers, who are influential members of the community, are likely to oppose FP programmes. Consequently, the survey suggests that soothsayers be consulted about specific strategies and that respected traditional community leaders be involved in the promotion of FP services.

The nature of demand. Demand for FP is complex and contradictory in some respects. Women cite large families as ideal, yet express a desire to limit their fertility. The current term for FP services *adog-maake*,



Consultation with traditional healers works, confrontation fails

If my husband marries a second woman and he does not want us to do (FP) and she doesn't do it, he will love her; he will not love me again. If he has something small, he will give it to her and leave me...In the night I will be sleeping alone with all my FP.

—Young Naga woman

which translates to “stopping childbearing,” further complicating the apparent intentions of programmes. Spacing childbirth is, however, well understood. Health workers must be retrained in outreach strategy and in ways to conceptually link primary health care and FP. Candid doorstep conversations, rather than simple woman-to-woman transmission of information, may foster broader and longer-term changes in attitudes.

Economic constraints

Extreme poverty. In an environment in which resources are scarce to find, women are compelled to turn to their husbands and family relations to pay for even things such as contraceptives. Under such circumstances, lowering the price of contraceptives does not eliminate financial barriers to access. Cost-sharing schemes and coupons may therefore be more effective at increasing FP use. Children represent economic value; however, families increasingly favor wage earning over farm labor. Programmes may generate demand by establishing credibility and emphasizing links to child survival.

Agrarian economy. Cash, long-range service delivery, and exposure to mass media are all limited. Music and cultural events communicating FP and other health themes may therefore be most effective. FP programmes may benefit from traditional networks such as men's cooperatives for harvesting and *Susu*, women's associations for trade, marketing, and lending, both in terms of information dissemination and in terms of employing existing means of sharing adversity.

Basic health care concerns. Mortality and morbidity indicators and rates of infectious diseases are high in Kassena-Nankana District (KND), and given limited resources and energy, FP programmes must show their own importance. These circumstances call for a shift

from the needs of bureaucracies, statisticians, and demographers towards those of the community. Durbars may therefore include discussions of sanitation, immunization, and common diseases in conjunction with FP information and services.

Faith in traditional medicine. Belief in traditional healers and soothsayers' advice often causes delays in seeking allopathic and nontraditional opinions. These traditional healers must be consulted about the formation and structures of proposed interventions.

Reproductive health and delivery problems. Given the prevalence of reproductive health problems and the high incidence of labor complications, an efficient referral system must be put in place and community health workers trained to screen and refer patients when the need arises.

Conclusion

From an assessment of these problems, the Navrongo staff proceeded to investigate what service delivery, community health education, and outreach strategies could be designed to optimally address them. Each problem was aligned with a proposed solution; each solution was tested in a micro-pilot, and focus groups were convened to gauge community reactions and to seek advice on ways to move forward. In this manner, social learning, listening, testing, and responding over time, became a resource for organizing the Community Health and Family Planning Project (CHFP).

supervision of primary health care; the Ministry of Health (MOH) outreach dimension seeks ways of moving health services from Level B Clinics to clients' doorsteps.

What works?

Community participation. While "community participation" is frequently deemed central to health policy, how to translate this concept into practical terms at the district level is often unclear. The CHFP addresses this knowledge gap by providing viable ways to develop community participation. Early in the CHFP pilot phase, it became evident that communities will donate labor towards constructing health facilities, known as community health compounds (CHCs). This interest is based on the widespread concern expressed in durbars that communities do not have access to health care. That primary health care (PHC) needs are not adequately addressed by subdistrict level clinical care alone places immediate demands on the CHFP. This community emphasis on clinical care sustains both interest in developing CHC and accountability of the health care system to those whom it serves. In building the CHC programme, the CHFP invoked institutions of chieftaincy, lineage, and social networks to provide support for services, supervision for volunteers, community health education, and FP themes that nurses could continue to promote. CHC have since become central to the success of the CHFP.

Volume 1, Number 8, 2001

JUST THE RIGHT AMOUNT OF COMMUNITY INVOLVEMENT

Introduction

The Navrongo experiment was launched in 1994 as a pilot project testing the mortality and fertility impact on primary health care of mobilizing untapped resources and shifting the locus of care delivery. The Project's *Zurugelu* (togetherness) dimension seeks ways of involving communities in the organization, delivery, and



Community durbar



Community Health Compound (CHC)

CHC. Community leaders can be mobilized in support of PHC and FP services. The process of community mobilisation builds male involvement and reduces the social tensions brought forth by the promotion of reproductive health care. Community leadership can reinforce MOH supervision.

Community-based services. It is possible to relocate nurses to CHC. Community-based para-medical care greatly increases the volume of services, improves immunization coverage, and expands the range and quality of reproductive health and ambulatory care. The strong preference for injectable contraception is addressed by doorstep- and CHC-based paramedical services. If conveniently accessible nursing services are combined with community mobilisation, health care and immunization coverage will improve, and FP practice will increase.

What fails?

Community participation. A community mobilisation strategy that is entirely dependent on community resources is often fraught with delays. Alternatively, a community outreach programme that is externally supported can induce community conflict or apathy. Small, external resources are therefore needed as incentives for community action rather than as replacements for it. In Navrongo, communities that were provided with District Assembly support for iron sheets or other CHC construction materials were much quicker to implement the programme than those that were either

totally deprived of or completely supported by external resources.

Community volunteers. The Navrongo project employed volunteer workers known as Yezura Zenna (YZ)—young men and women committed to improving the standards of health and well being in their community. Cells testing community health mobilisation show that community outreach alone (without resident nurse service support) has no impact on fertility or mortality. In fact, the Bamako approach may divert parental health seeking behavior from relatively costly, but effective, paramedical services to inexpensive and convenient, but ineffective, volunteer-provided services. This issue is unresolved, however, and further research is needed before definitive conclusion can be drawn. Nevertheless, findings suggest that community participation and volunteerism should be directed towards health promotion and service system support, but the provision of treatment and care should be left to trained MOH paramedics.

MOH community-based services. Doorstep FP services had an impact on fertility only in cells of the experiment where community mobilisation was developed. Community-based delivery will fail unless traditional leaders, lineage heads, and men are mobilized to support the programme. Successful community mobilisation empowers women to exert their reproductive preferences. Failure to mobilize the community fatally weakens MOH outreach. Involving leaders, however, creates a mechanism for male involvement.

Perinatal health and neonatal survival. The Navrongo experiment has yet to demonstrate an impact



A Yezura Zenna (YZ) providing doorstep services



Community Health Officer (CHO) providing service

on mortality in the first month of life. There is a need to test feasible means of providing emergency obstetric care in settings where access to delivery services is constrained by the absence of communication, transportation, or ambulatory care.

Conclusion

Appropriate community involvement is complexly determined, and must be carefully equilibrated, accounting for programmatic, MOH, community nurse, community male and volunteer roles.

Volume 1, Number 9, 2001

THE COMMUNITY AS CLASSROOM

Training in reproductive health services and primary health care is often planned as a four-corner classroom exercise involving lecturing, listening, and learning by rote rather than as an exercise in learning from practical example through counterpart exchanges. Also, programme planning is something that is usually pursued in an office far removed from the communities that plans are intended to serve. Management can also take on a top-down character rather than something that is informed by community experience of service workers. The design of the Navrongo CHFP is based on

“learning-by-doing” in which planners, workers, and leaders are guided by community opinion and leadership. All operational components of the programme have been developed on a pilot basis; each pilot involved village trial, and community feedback on what has worked and what has failed. Training programmes associated with the CHFP have placed maximum attention on learning in the village and peer leadership—a concept of learning whereby workers who are experienced at an activity train counterparts while actual services are being provided. Transferring lessons from the Navrongo project to other districts has also emphasized practical demonstration. Taken together, this programme is organized as an initiative in which communities serve as the primary classrooms for developing management, worker, and trainer capacity to conduct the CHFP. Unlike other initiatives, which conduct training at the beginning of a programme, “learning-by-doing” is a continuous process in the CHFP.

Social learning and capacity building

From the onset of the CHFP two individuals have played a crucial role in capacity building. Developing the CHFP has not been pursued with trainers brought in from outside the study area or pursued as coursework in a regional or national programme. Developing the CHFP required district health management team



Learning from fellow men



Community Liaison Officer, Community Health and Family Planning Project (CHFP) staff member, and a community health officer

(DHMT) commitment, direction, and leadership. Since capacity building is not a conventional DHMT role within the MOH system, it is important for the DDHS to designate two individuals in this effort: i) a Training Coordinator who will plan the content, timing, and duration of training activities, and a ii) A “Community Liaison Officer” who consults with community leaders, encourages collective action, and deals with problems through diplomacy and discussions.

Social learning as a management tool: The work of the “Community Liaison Officer.” Ever since the CHFP was launched, community groups have been assembled to discuss activities and advise the programme about ways to improve operations. Assessing community-training resources is the job of the Community Liaison Officer. The Community Liaison Officer convenes social groups that naturally assemble in Kassena-Nankana society to assess reactions to operations, seek community advice on training needs, and identify gaps in the service regimen. Groups identified for consultation include Chiefs and elders, social networks of older women, young married women, and young married men. Assessing community reactions by systematically convening these groups and listening to their advice provides a mechanism for community leadership in capacity building activities.

Role of the Training Coordinator The Training Coordinator organises training sessions, prepares and manages timetables and budgets, documents plans and gathers resources, and identifies local resources. A district may have an unusually active and creative community health officer (CHO) or a dedicated Chief or a committed Assemblyman. After the Community Liaison Officer has identified the training needs of the community by soliciting the opinion of the people, actual training activities are coordinated by the Training Coordinator who is a full-time DHMT member responsible for deploying workers to the village as well as planning training sessions.

The “Counterpart Training” Concept. Counter-part training represents a concept in which service delivery staff, such as CHO serve as on-the-job trainers. Under ideal circumstances, village counter-part training involves an entire cycle of community health service visitation and outreach, running for about three months. In practice, however, much shorter periods of time have been used owing to inadequate staffing, equipment shortages, and accommodation problems.

For CHO, “counterpart training” is designed to demonstrate all aspects of the CHFP service regimen: i) comprehensive immunization services; ii) safe motherhood counseling and delivery services (if opportunities for midwifery care arise); iii) treatment of febrile illnesses; iv) diarrhoeal disease therapy; v) reproductive health counseling, and FP service



Teamwork—community health officer (CHO) and community members working closely together



District Health Management Team (DHMT) staff taking community health officer (CHO) through a training session

delivery; and other ambulatory care or referral services. Training also involves orientation to record keeping and monitoring, community entry and mobilization activities, and volunteer programme coordination.

For supervisors, “counterpart training” involves attaching a trainee-supervisor to a role-model supervisor who serves as a guide for field activities. This involves demonstrating community diplomacy, CHO support requirements, training activities, and other elements of community health care supervisory operations.

Finally, entire DHMT and counterpart teams have been trained in Navrongo to establish “lead districts” in other regions of Ghana. At every stage of these orientation sessions, communities are involved in training visiting teams and workers at all levels serve as trainers. In this manner, the communities served by the CHFP have become classrooms for training health professionals in ways to replicate operations in other areas of Ghana.

Conclusion

Using the CHFP for developing community health and FP services elsewhere involves applying the Navrongo process of capacity building as much as it involves technical components of the programme. The process involves listening to the community, adapting services to local realities and needs, and developing training approaches that involve workers and community members. Throughout this process, the community is the basis for all learning about what works and what fails.

Volume 2, Number 4, 2002

WHERE THERE IS NO COMMUNITY

The ideal community is a place where people live in harmony, with activities of common interest organised by benevolent Chiefs, and implemented with enthusiasm by community-spirited volunteers. Unfortunately, such communities don't exist. In fact, in some districts there are communities that are leaderless, plagued by endless conflicts and thereby lacking social cohesion. In such communities, the elegant CHFP community entry procedures for soliciting the cooperation and support of traditional authorities and community members may fail to foster community action. In the case of the CHFP—or what is now referred to as the Navrongo service model—health service planning is directed to community needs and health reorganization begins with community consultation and dialogue. Community leaders are involved in all aspects of primary health care delivery: design, implementation, monitoring, supervision, and evaluation of interventions.

Communities are mobilized to provide residences or construct CHCs where nurses relocate to provide door-to-door health care. Health committees are constituted to supervise the work of community health volunteers who are trained to provide basic curative as well as preventive health services. However, in two communities where Chiefs were not involved from start to finish in the design and execution of programmes, the system was never launched until unconventional action was taken to deal with the absence of community organization.



Community health compound (CHC) overgrown with weeds—where is the community?

What went wrong?

For the most part the new health delivery approach introduced by the CHFP has been embraced with gusto. But, while some communities put their heads, hearts, and hands into the programme—with the active support of community leaders—others were less enthusiastic, almost apathetic. Is it possible that communities may not be interested in their own affairs, their own health? What should be done in settings where people do not show interest and participation in promoting health service delivery? What is appropriate in settings where there are no communities?

Durbars have been a mainstay of the CHFP design, but in 'nonexisting' communities, such meetings of community members could not be organised. Messages to be delivered to its members regarding the concept of community-based health service delivery never took place. Where communities showed little interest in durbars, support for constructing a CHC was totally lacking. It was reasonable to assume that community volunteers would not contribute their labour for CHC maintenance, which, in rural Kassena-Nankana, is a yearly necessity.

In one such community, discussions were continually held with the Chief and some elders; yet, when it came to meeting community members at a durbar, problems cropped up, most of the people did not attend. Since it was always a few people who got the health service delivery message, the request for the



Other communities just sing to their health

community to provide or construct a CHC could not take effect and that delayed the posting of the CHO at the initial stages. Several visits were made to the Regent who acted as Chief after the death of the Chief and before the enskinment of a substantive Chief. All efforts to get the Regent to call a durbar were unsuccessful. Flimsy excuses, such as a funeral preventing the people from attending the durbar, took the place of concrete actions. This community was referred to as 'a community in absentia' and the "uncommunity."

After several months of fruitless attempts to get the community together, a prominent member of the community visited home from a major southern city. As a well-respected personality in the community—especially by the youth—he was recognized by the CHFP as someone who could catalyze community action. When the individual was contacted he willingly agreed to organise a grand durbar where project staff could address a large gathering. Later he organised youth to mould bricks and with his supervision, the CHC was constructed. The CHFP assisted the community by providing roofing material, cement for the floor, and bitumen for stabilising the walls. Afterwards, an impressive and well-attended durbar was organised to introduce the CHO, YZ, and YN.

Chiefs and elders who had done nothing to foster this action were invited to participate in the durbars, in recognition of their traditional roles of honour. But all present knew the true dynamics of progress. Traditional



Where there is a community, even little children give the nurse a helping hand

leaders were motivated by the experience to take the initiative seriously and cooperation with the CHFP improved.

What works?

Where there is no sense of community, it takes more than the Chief and his elders to organise people to participate in local initiatives to promote health. The active participation of community members in health service delivery or for that matter, any community-based activity, should not be taken for granted. To successfully deploy nurses to the communities and for them to perform effectively, an influential person may be needed to inspire people and organise them for communal work, especially when it comes to the construction of CHC or their maintenance. Therefore, the Chief should not be the only person to rely on to organise people for communal work. In some communities the Chief is regarded only as a ceremonial head who does not wield sufficient power to organise the people to carry out an activity. It is sometimes necessary to search for an opinion leader to organize community members. Various options are available: school teachers, Assemblymen, social network leaders, women's groups, church groups, and economic networks.

Conclusion

Where traditional leadership is weak or lacking, it is important to convene discussion groups of women and men to guide the programme on feasible means for moving forward with alternative leadership designs. CHO and volunteers remain deployed throughout all experimental areas in Kassena-Nankana to offer services, clearly shows that it is possible to promote health service delivery even in areas where there are no communities!

Volume 2, Number 21, 2002

PUTTING TRADITION TO WORK

In closely-knit societies such as those that exist in Africa, practices abound that provide the framework for

understanding and defining relationships, attitudes, actions, and general behavioral patterns. Often, adherence to these cultural values is identified as a constraint on the implementation of development projects aimed at promoting the wellbeing of both the individual and the community. The potential for mobilising these cultural resources for social change has never been seriously considered.

Today, an experiment in a remote and rural setting in northern Ghana has dissipated the negative perception that culture is potentially inimical to progress. Contrary to conventional wisdom, the CHFP in the KND of the Upper East region has successfully demonstrated that cultural institutions can be deployed as powerful resources for promoting health and FP in an environment where the demand and utilization of such services has been consistently low. The invaluable cultural resource in question is called a durbar or the Village Parliament. A durbar is a traditional gathering convened by Chiefs, elders, and opinion leaders of a community or village. More often than not, it is associated with festive occasions like traditional festivals or the enskinment of a new traditional ruler. Durbars are often organized to build community commitment for a new idea, course of action or to implement a new decision. Politicians at the local, national and international level use durbars as a resource for party organization and political campaigning. During



Traditional leaders make it to the durbar grounds in resplendent regalia



Warming up onto the durbar grounds

election time politicians organize durbars to inform and convince the electorate to subscribe to an agenda for bringing positive influence to the country or the local electoral area.

In the search for an appropriate approach to mobilize local communities for collective action, the NHRC has identified the durbar as a valuable cultural tool for health communication.

A durbar typically begins amid considerable formality, pomp and pageantry, drumming, dancing, and singing. Ultimately the gathering becomes an open public forum of dialogue, public speech, debate, and discussion of pertinent social issues. Through the village crier or some such other local level communication channel, a message, either from or certified by the Chief, is passed from house to house. Usually a person climbs upstairs and calls out to another in the nearest compound and passes on the message. That person also passes the message on to the next compound until all compounds are covered. The purpose of the gathering and the venue, which is usually at the market place, is communicated. The possibility of anyone missing the message is virtually nonexistent. On the day of the durbar, which may be a market day, everything starts slowly like a serious joke. Drummers and artists from the various sections of the community are notified. They are usually among the first to move towards the durbar grounds as a signal

that the time for the Village Parliamentary session is well nigh. People put on their best attire, usually a carefully handwoven smock that attests to the sophisticated craftsmanship of its weaver, and begin to ooze out, nonchalantly, onto the durbar grounds. The Chief is usually the last to arrive but it is not unusual for the Chief to be among the first.

At about the appointed time sufficient numbers would have gathered for the ceremony to begin. It is normal for a ceremony to begin several minutes earlier or later since time is not measured by chronometer but by the length of shadows. The durbar itself can be a short or protracted ceremony. People usually sit in a circle so that as many people as possible have a good view of what is happening. While drumming goes on in the background, visitors go to shake hands first, and then the community leadership officially welcomes them with another round of handshakes. The chief or community leader, in this case the 'Speaker' of the Assembly, gives the welcome address before inviting the visitors to speak. The Guests state their mission. In the case of the CHFP, the DHMT and the NHRC launch discussions on the health problems in the community and provoke a brainstorming session (a parliamentary debate) on how to tackle them. Decorum is strictly observed and the Speaker or his designated assistant gives 'Parliamentarians' permission to speak one after the other. Queries are raised, questions asked, and



Keeping a watchful eye on every event



Children enjoying the deep fries at a durbar—outside the epicenter of vigorous activity

clarifications sought. Words are carefully chosen and every effort is made not to offend the sensibilities of others. In any case, there is always the ‘Chief Whip’ to bring errant Parliamentarians back to order. As it were, no Parliamentarian speaks to say nothing. Quite unlike in modern parliamentary sessions, there are no jeers and boos, and there are no majority and minority sides and leaders.

The durbar initiative provides the channel for communicating with the various villages. It provided the platform for discussing, explaining, and introducing the

CHFP. After a series of durbars the system of Village Health Volunteer and Village Health Committee was developed for health service delivery in the district.

By using durbars as a communication tool, health development programmes that would have otherwise cause confusion in the communities are legitimized. Using durbars as a cultural resource has made it possible for health personnel to mobilise the community, disseminate health information, plan health activities, and implement them. The durbar initiative adopted by the Navrongo Experiment offers an opportunity to bring the health hierarchy and traditional authorities together to discuss health problems and find lasting solutions. By using the method, the top-down approach of the conventional health care system is gradually being replaced by the bottom-up planning of health care; one of the hallmarks of health service decentralization. Durbars also provide a great opportunity for informing the District political leadership of health problems in the community. The presence of local government officials at durbars gives health programmes political support and legitimacy. Durbars have created the grounds for mobilising all sociocultural resources and institutions like peer groups, women’s groups, opinion leaders, elders, family heads, landlords, village committees, and soothsayers in the KND to implement a community-based health and FP programme.

Community health compounds

Volume 1, Number 13, 2001

GIVING HEALTH A HOME

Just as the people live in communities and reside in compounds, health care can be community-resident and provided a home. The idea of a community health compound (CHC) is a component of the Community Health and Family Planning Project (CHFP) that was invented by the people who are the project's target beneficiaries. At the very beginning of the project, when communities were approached and asked about their needs, leaders uniformly asked for a "hospital" to be built in their locality. When health care expectations were discussed, it was clear that the community health care needs could be met if the existing Government of Ghana plan to decentralise access to Primary Health Care (PHC), including family planning (FP) services, could be achieved. This desire from communities therefore corresponds with a longstanding policy of the Ministry of Health (MOH). Since the 1970s, developing community health care has been a priority of the MOH. But, by the early 1990s, evidence was overwhelming that no satisfactory results were forthcoming because the services of community health nurses, who were posted to work at "Level B" clinics, were inaccessible to a large proportion of rural households. This system of health service delivery was re-examined and the results were that it was time to take health care to the doorstep. The CHFP experiment, whose aim was to determine the most efficient way to go about this, was a welcome idea to the MOH. It was also a major concern of the people of Kassena-Nankana District (KND).

The idea of a CHC

No district in Ghana can afford to build a "hospital" in every village. However, with community members acting



Chief in his palace

as consultants, consensus was reached in every CHFP study community that traditional compounds could be built to serve as a home for health care workers. Agreements were made with each community, whereby community health nurses (CHNs) were to be retrained and reoriented to function as village-based health service providers. They were redesignated as community health officers (CHOs). To address the problem of where CHOs would live and offer services to the community, construction teams were organized by Chiefs and elders to construct compounds with traditional materials. The logic was simple: If residents of the district can live in compounds; health care can also be CHC-based. Will later developments prove or disprove this logic?

Building community participation by building CHC

Community participation is sometimes difficult to develop. The CHC mechanism has been a useful mechanism for focusing community attention on the programme and developing a sense of community ownership of the health service system. This was achieved by:

- *Approaching Chiefs and elders.* Making plans, developing health committees, constituting volunteer groups, and other organizational tasks could be initially focused on the CHC construction need. The process of dialogue and community action established mechanisms for community leadership that could be extended and developed in the CHFP.
- *Developing male ownership.* All lineal groups were expected to participate in construction. This provided a means of involving men in the planning and implementation of the programme.
- *Building community pride.* Durbars and celebration of milestones in the programme provided a basis for recognizing leadership, awarding participation, and developing community pride in the programme that they were building.
- *Nurturing support for the presence of nurses.* When communities completed CHC construction, a *durbar* was convened to celebrate progress and introduce the CHO assigned to the community. In this manner, the CHO assignment represented a reward to the community for work that they had



Zurugelu at work—community members putting up a community health compound (CHC)



Community members undertaking maintenance work on a community health compound (CHC)

invested in health care. Attention was directed to her assignment, not as the posting of some external worker, but as a new member of the community in charge of health development.

The essential elements of a CHC

The 16 CHC constructed in the District all share common features. These include:

- A walled courtyard with a cement floor and secure gate;
- A shaded waiting area for patients;
- Structures which provide a room for clinical services and a separate room for a living space;
- Latrine/place of convenience;
- A kitchen, and;
- A bathhouse.

Conclusion

The construction of CHC has been valuable to the CHFP, not only as a means of housing nurses in convenient locations, but also as a means of building community participation in the programme. While the CHC component of the CHFP represents a major feature of what works in the projects, there are also lessons learned about what fails.

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GIVING HEALTH AN ADEQUATE HOME: BUILDING CHC THAT WORK

The CHFP has demonstrated that locating nurses to the community is feasible and effective. The key to this strategy has been to involve communities in the construction of CHCs. Trial and error has produced insights into strategies that work:

1) The first attempt involved a completely community-donated structure that was built entirely with traditional materials. While community members expected the CHFP to provide external funding for modern CHC construction, the CHFP recommended simple construction utilizing community-donated resources and volunteer labour for the entire project. No plan was given to the community; instead, they were left to develop the facility without assistance or external advice. In response to this initial approach, three communities constructed two-room laterite residences with a perimeter wall, a bath area, kitchen and a latrine pit. This approach failed.

2) The failed CHC initiative was followed by improved designs constructed with traditional wall material with iron sheet roofing, cement flooring, and a cement-sealed latrine. Materials were supposed to be community donated, but progress in most remaining villages in the study area was delayed due to community resource constraints. The need for cash outlays for construction items, such as tin roofing sheets, bitumen (for stabilising the walls), wood for windows and doors, and cement for the floors delayed construction. This was resolved in several communities that successfully approached the District Assembly for seed funds. Basic furniture and equipment was provided in this manner. This composite structure has enabled the CHFP to get started and operate since 1996. But, the use of laterite wall material has proved to be difficult to sustain and requires continuous community liaison and problem solving.

3) The CHFP experience with facility development has led to the conclusion that no existing CHC in CHFP study areas is, as yet, the optimal model. An optimal



First community health compound (CHC) that failed: Completely traditional material

model would require external resources for cement walls, floors, and corrugated iron roofing sheets.

By trial and error some lessons have been learned
Locating CHC. Communities participating in the CHFP initially determined where to locate the nurse without guidance from project staff. In some communities, leaders assumed that a nurse would feel isolated and lonely if she lived separately and alone. CHO were therefore provided with dwelling places located in close proximity to other people. In some communities, it was suggested that this was best achieved by placing the nurse's residence either in or near the Chief's palace. But the project soon learned that this approach was not welcomed. People who shared compounds with CHO were concerned that they were being exposed to risks of being infected with diseases since the nurse received patients in the house and treated them there. For the CHO who lived in the Chief's compound, patients and clients complained that a Chief's palace is a public place where anyone in the community could visit; there was therefore no privacy, which to them, was of paramount importance. These were genuine concerns, which the programme implementers took into consideration during the scaling-up of the experiment.

Lesson learned: Locating a CHC requires careful dialogue, not only with community leaders but also with women and men who will use the facility for care.

CHFP CHC are typically sited near markets, roads, water sources, and other accessible places. Above all, a CHC is centrally located and care is taken to ensure that no single person or groups of people are seen to have unduly influenced the location of a CHC. Privacy of patients and confidentiality of clients are guaranteed.

Making CHC too simple: Nonsustainable traditional construction

Traditional CHC are maintenance intensive. This is a labourious task without which the CHC will not last more than a couple of years. According to tradition, women are expected to plaster walls and repair roofs of compounds. The CHO is too occupied with her numerous tasks and household chores to spend time on the maintenance of the compound. Women in the community cannot make time for CHC maintenance due to their own activities that include maintaining their own compounds. *The experience of the project is clear: Use of strictly traditional construction materials produces CHC that are not sustainable.* Nurses assigned to overly simple and locally constructed CHC complained of poor living conditions. While the traditional CHC construction was seemingly affordable, savings were outweighed by the cost of low morale and poor productivity.



Second attempt: An interim design that is difficult to sustain



The ideal community health compound (CHC) in Bolgatanga District

Undermining community participation with external resources

In one community, a foreign visitor approached the Paramount Chief about constructing a CHC. Without developing a plan for community action and participation, he left funds behind for construction. While resources were available for quite an elaborate facility, construction was much slower in this community than in communities where resources were relatively constrained. Initiative was extracted from the community by external largesse. Factionalism ensued, volunteerism was undermined, and complicated diplomacy was required to foster community action. It is important to establish that community action is organized and that work begins before external resources are committed.

Conclusion

Purely traditionally designed and constructed CHC are not sustainable. The CHFP has maintained its original simple design for the CHC but the need exists for a more robust building constructed with cement blocks and roofed with corrugated iron sheets. The introduction of external resources must be pursued with care, so that supplies represent an incentive for community participation in the CHC construction programme, not a substitute for community initiative.

Volume 2, Number 19, 2002

WHERE DO WE PUT OUR CHC?

In 1994, two villages, Kayoro and Naga, were the first Navrongo Project communities to construct CHCs. Then, as now, CHC were intended to serve as dwelling places and clinics for CHOs to serve as frontline service providers of the CHFP. The two communities share one clear thing in common they are the most isolated communities in the essentially rural KND where everything including health service, is remote and difficult to reach. Naga is 45 kilometers to the South of the central part of the district where the district hospital is located, and Kayoro is 40 kilometers to the West and both communities are about 15 kilometers away from the nearest health facility. Residents of these remote communities are therefore the most enthusiastic participants in the project. Bringing health to the doorstep could not have been possible without their CHC.

While it may be obvious that a community needs a CHC, the logical place to put it is often less obvious. Influential leaders may want to situate it near their compound. Or, there may be community groups vying for one location or another. In general, what works in CHC placement is finding a location that is convenient, but not so close to any community group that its construction appears to exclude others. Achieving a



Chief and Elders massaging the community health compound (CHC) idea



Where do we locate our community health compound (CHC)?

consensus about the location involves consultation with community leaders, group consultation with individuals who will use the CHC, such as mothers with young children, and open discussion of the CHC programme at a durbar where the construction plan is announced. Here, novel but workable ideas emerge, all of which are melted in the crucible of open discussions. Some of the most absurd views often lead to practical solutions. While there is no general formula that will always work, some guiding principles usually apply that were first worked out in Kayoro and Naga:

- Locating the CHC next to, or inside a chief's compound, typically fails. Women seek an element of privacy and social distance between the CHC and places in the community where leaders reside.
- Locating the CHC near a well or borehole helps the CHO by providing convenient access to water, and clientele, and convenient access to a service point. In some communities where water is particularly lacking, schoolgirls in the vicinity take it upon themselves to fetch water for the nurse, wherever they can find it.
- In settings where there are multiple communities to be served, it is important to locate the CHC in a place that is not perceived to be owned by a



Women in a focus group discussion about where to locate their community health compound (CHC)

particular social group. Finding the right location in such situations can be a challenging task.

While these principles often apply, there is no general rule or formula for answering the question “Where do we put our CHC?” Situating a CHC involves dialogue with community groups. This involves dialogue with:

- *Chiefs and elders.* Community dialogue should begin by assessing the views of community leaders. These views should provide the basis for discussions that follow.
- *Young mothers.* Since women and their children are important clientele, it is important to convene groups of women from the community to be served and seek their advice about where to place the CHC. Young mothers should have ample opportunity to air their views on where a CHC should be placed.
- *Wives of compound heads.* In many compounds, the mobility of women is influenced by the senior women. Wives of compound heads are particularly important health access opinion leaders. Separate groups of older women should be convened to discuss the matter of where to place a CHC.
- *Husbands.* Men should also be involved in the dialogue so that no group is excluded in deliberations. Men have often been found guilty of

exerting unhealthy influence on the health seeking behaviour of women, especially their wives.

At the end of the process of community dialogue, leaders should be reconvened and apprised of what has been learned. Consensus should be forged at this stage and a durbar planned to announce the decision and solicit open community comment on the choice of the site and plans for building the CHC. Constructing consensus about location is critical to constructing effective CHC. The people of Karyoro and Naga have taught us how to build this consensus.

Volume 2, Number 20, 2002

ONE BRICK AT A TIME

The concept of building CHCs is often misunderstood. District Health Management Teams (DHMT) planning for the CHPS programme see the CHC as something that costs money, and therefore something that must wait for funds to arrive. Communities in the CHFP demonstrate another approach: Begin by starting with whatever resources are available to build a CHC that is constructed with local material, maintained with community labour, and supported by a broad consensus that health care cannot wait. Then, from the position of achievement and success, utilize the functioning CHC as



Digging the foundation under the supervision of the Chief and people

The community health compound (CHC) concept utilizes Kassena-Nankana tradition for constructing compounds . . .



. . . to house nurses who provide primary healthcare services



The original Kayoro community-donated community health compound (CHC)

a magnet for acquiring funds for putting up a better structure where health can be adequately housed. In short, build the primary health care programme one brick at a time. This approach is demonstrated by two Navrongo Project communities, Kayoro and Naga which built and maintained their own compounds to house the resident nurse in 1994. The buildings that were constructed are not a model for others to emulate: Torrential rains in the course of the first year collapsed exterior walls of both of these CHC, leaving them in a very bad state. But, in 1995 District resources were found to renovate the CHC with iron sheet roofs, cement floors, and simple amenities, such as a latrine. These very simple CHC functioned for the next six years. By 2002, they were once again on the brink of collapse, rendering them uninhabitable. The disruption threatened to derail health service delivery. As a result of

the importance of these CHC, efforts were quickly mobilised to get them functioning again. While CHC have been a continuing source of maintenance problems since 1994, communities have received continuing doorstep health care from the CHOs who worked out of the CHC. The experience of Naga and Kayoro shows that the 'one brick at a time' approach to developing adequate CHC can revolutionize access to health care.

Today, in Naga and in Kayoro, new and modern CHCs are under construction, owing to modest external funds that have been acquired to supplement community resources. The success of the Naga and Kayoro community-donated and -financed CHC has been used to seek funds for rewarding community action and initiative. Some features of the new CHC are informed by past success:

- *Location.* It is no coincidence that, in both communities the new CHC is less than 200 meters away from the old one. Community involvement in site selection produced locations that differ little from community selected sites for the original CHC.
- *Community involvement.* Building community involvement was crucial to building the CHC. This involved getting initial practical demonstration of commitment that in spite of the approach of the farming season, people can be mobilised for construction work.
- *Community innovation and initiative.* It is important not to standardize the construction programme.



Women are often prepared to risk their health to get a community health compound (CHC) constructed



Two headpans are better than one: Mason provided by the District Assembly casting the foundation concrete

CHC construction does not involve contractors or rigid GHS instructions. This is important for maintaining community commitment and initiative. For example, the western part of the district is generally rocky, and stone is not readily available in Kayoro especially around the area earmarked for the CHC. The chief devised a strategy of breaking the people into groups to work by sections. Division of labour was working to perfection at the community level. Where stone is available, that section concentrated on collecting stone while other sections gathered sand. Women and children supplied water. The District Assembly, the highest political authority in the district, kept their part of the deal

by providing a truck and a driver to cart the sand to the building site. They also provided an engineer and a mason to train community volunteers. The project offered building tools such as moulds, shovels, pick axes, trowels and head pans and the community members gave what they have in abundance: labour. Sometimes there were more people at site ready to work than there were tools to work with! This has been particularly the case with the Kayoro project. Then, one brick at a time, the Kayoro project was soon to overtake the Naga CHC which started one month earlier.

- *Community support for the service system.* The CHC is a crucial component of the CHFP service delivery model. Once CHOs are retrained, equipped and redeployed, they need a place to live and work. One element that is often taken for granted is patronage of the services for which the CHC is constructed. People must not only be passionate about helping the nurse relocate and integrate into the community but they must, above all, patronize the services brought to their doorstep.

What is worth noting about the Naga and Kayoro CHC construction approach is that they started the programme with their own resources, then a better CHC was constructed with project resources such as a DHMT can afford. It is the success in implementing the programme that attracted external resources for building a CHC component of the programme that works, one brick at a time.

Essential equipment and logistics

Volume 2, Number 7, 2002

KEEPING THE DRUGS FLOWING

Introduction

The Concept of Essential Drugs. In a 1975 report to the 28th World Health Assembly, the Director-General reviewed the main drug problems facing developing countries and outlined a range of new drug policies, based in part on the experience gained in some countries where essential drug schemes have been implemented.

In 1981, an action-oriented strategy titled the “Action Programme on Essential Drugs” was established within the World Health Organization (WHO) to aid member countries in the selection, procurement, training, information, and evaluation of essential drug policies. The introduction of the action programme was aimed at providing a few specific, essential drugs that would be available on the market and satisfy basic pharmaceutical needs of underserved populations.

Drug Policy. The provision of essential drugs is one of the objectives of Ghana’s Drug Policy, which aims to make essential, effective, safe, affordable drugs available to meeting the needs of the entire population and ensure the rational and efficient use of drugs. In 1971, hospital services were introduced through the Hospital Fee Act which removed subsidies and mandated fee collection for all health services.

The Bamako Initiative. The Bamako Initiative was introduced at a meeting of African health ministers in September 1987 in Bamako, Mali, with the aim of accelerating primary health care through community financing of essential drugs and other aspects of quality of services. In Ghana, essential drug revolving funds are established to sustain the replenishment of drugs and local operation costs.

The Community Health and Family Planning Project (CHFP) Approach. Under the Navrongo CHFP, community health officers (CHOs), and volunteers (Yezura Zenna [YZ]) have been trained to provide curative, preventive, and referral services to community members. They are provided with drugs for the treatment of minor ailments. CHOs treat various illnesses, including maladies that require antibiotic therapy.

From the outset it was decided that the first supply of drugs should be procured by the Project to serve as the basis of a revolving fund. Drugs flow to communities through two revolving accounts, one for each type of worker: i) CHO provide doorstep services and also provide care at community health compounds (CHCs). Funds generated by prescriptions are passed on to supervisors who are responsible for replenishing supplies; ii) YZ dispense drugs that are maintained in a community pharmaceutical kit managed by a committee. This committee, known as the Yezura



Community Health Officer (CHO) may offer injections; a health volunteer cannot



Accessibility and affordability are two sides of the same tablet

Nakwa (YN), manage accounts and replenish YZ supplies. Supervisors, in turn, check accounts and replenish YN pharmaceutical kits. Taken together, the CHO and YZ service operations generate resources for the District Health Management Teams (DHMT) to use at the Central Medical Stores for restocking supplies.

Drugs for YZ include Paracetamol for aches and pains, Chloroquine for the treatment of malaria, ORS for diarrhea, Aludrox for abdominal pains, Multivite for improving nutritional inadequacies, Piriton for itching from allergic reaction to chloroquine, condoms for family planning (FP) and protection against STDs/AIDS, Conceptrol (foaming tablet) for FP, and oral contraceptive pills.

Each community has developed a drug-management system suited to its needs. However, all YZ and YN are trained in recordkeeping and supply management to ensure that drugs keep flowing as needed. When the drugs for each community are collected for the first time, the community decides on the price to be charged. YN training is directed to orienting committees on prices charged elsewhere and procedures for determining appropriate charges for their particular situation. A small profit margin is figured into the cost of each drug and is used to maintain YZ bicycles and provide minimal incentives for the volunteers. Selling prices to community members are reviewed whenever there is an increase in the cost of drugs.

Management for accountability. Drugs are collected from the DHMT/Navrongo Health Research Centre (NHRC) by the YN and stored in a lockable wooden box. In some communities the YN entrust money to the YZ to pay for and collect drugs at the DHMT/NHRC and, on return, hand them over to the YN before the drugs are reissued to them. The box in most cases is kept with the Chairman, the Secretary, or the Treasurer. In some communities the box is kept with one member of the YN while the key to the box is with another member to ensure security. Maintaining security and transparency is important at all times.

In two communities, Nakolo Central and Boania for instance, where the Chairman and the Treasurer cannot read or write, the box is with the Chairman, and the keys are with the Secretary. When the YZ needs drugs, he goes to the Secretary, picks up the key to the box, and together they go to the Chairman's house and the box is opened in the presence of the Chairman, Secretary, and YZ before drugs are issued. The Secretary then records the quantities of drugs issued into a ledger and locks the box. When it is time for the YZ to pay money from drug sales, the Secretary goes with the YZ to the Treasurer where the YZ settles up and the amount is recorded.

In ten communities the box is kept by the Treasurer who, in some instances, is the keeper of the key. The Treasurer collects money from the YZ for drugs sold and issues him with a new stock. In seven communities the drug box and keys are kept with the Chairman who issues the drugs to the YZ, collects money from drug sales, and then accounts the money to the Treasurer.

With an average recovery rate of 83%, overall drug management has been successful. The main problems are with respect to community members who are unable to afford the full course of treatment for ailments such as malaria. Drugs are sometimes dispensed in emergency situations even though payment is not possible and must be deferred.

Conclusion

In general, policies that keep drugs flowing depend upon policies that recover costs. As long as resources are available

for replenishing supplies, single management procedures can be developed to ensure sustainable drug flow.

Volume 2, Number 8, 2002

A GOOD IDEA THAT FAILS: DRUG EXEMPTIONS IN THE CONTEXT OF DOORSTEP CARE

The Navrongo Experiment trains CHOs to provide as wide a range of services as possible. Since they are certified paramedics of the Ghana Health Service (GHS) they offer a more extensive range of drugs than the volunteer YZ's can provide. The main difference is that, unlike YZ who are not allowed to handle or dispense antibiotics, CHO dispense antibiotics and may give injections when the need arises. In addition to all the drugs that YZ handle, CHO, at any point in time, have the following drugs in stock:

- Folic acid for nutritional inadequacies;
- Mebendazole for intestinal parasites;
- Salbutamol for asthma attacks;
- Penicillin V, Co-trimoxazole, Amoxycillin and Metronidazole as antibiotics/anti-infectives and;
- Eye ointment/drops for eye infections.



A community health officer (CHO) has more exemption cases than she has free drugs to offer



Children waiting for their nurse to come—with or without free drugs

CHO provide the full complement of FP services: Depo Provera, oral contraceptive pills, foaming tablets, and condoms as well as counseling, treatment of minor side effects, and referral services.

In 1999, the CHFP implemented the Ministry of Health “Exemptions Policy” which entitled all children under five years of age, pregnant women, and the elderly, that is, people of 70 years and above, to free drugs. Under this policy, available stocks of drugs are distributed with each prescription generating “Exemption vouchers”. These in turn are accumulated for the Regional Health Administration to release funds for the purchase of new supplies to replenish stocks through the regional pharmacy. But, since CHO are so active in reaching exemption cases through doorstep services, the pace of service delivery quickly outstripped the resources of the Regional Health Administration. This led to severe lapses in the flow of drugs, and basic CHFP services were impaired. Some nurses even abandoned community-based care altogether. Without drugs for treatment, the entire programme lost its rationale.

Responding to exemption failures

The CHFP responded to the Exemptions Policy failure by developing community participation in cost recovery. Simply imposing charges would have generated misunderstanding. However, community dialogue about the problem led to fees for drugs dispensed at the

doorstep and the CHC. After dialogue with each community, as with YZ, the community determines the prices at which drugs handled by CHO are sold. Agreements are based on the notion of reciprocity. The GHS supports CHO residency in the community and provides fuel for their motorbikes. The communities share in the costs of the programme by financing the pharmaceutical component of care. Once services are launched, drugs are stored in a lockable box and kept by the CHO who collects them from the DHMT and the CHFP. She takes a small quantity of drugs at a time when she goes on compound-to-compound visits. As she treats patients and prescribes drugs the patients “cash and carry.” When her drugs are running out or when she has money from an old consignment of drugs, she sends the money and renders accounts directly to the DHMT/CHFP and collects new drugs. With regard to FP, CHO collect FP devices from the District Public Health Nurse (DPHN), offer them to clients and render accounts back to her. When a DPHN is proceeding on leave and another has to relieve her, it is the DHMT, the sub-district or the CHFP that supervises the handing over of drugs to the relieving DPHN. Once a month an inventory of the drugs on hold by the CHO is checked to make sure that they are accounted for.

CHO face unique problems in the course of their duties with respect to the management of drugs. For example, CHO often come into contact with patients who cannot afford to pay for a simple malaria course. Some pay for drugs by installments and others plead to take the drugs on credit and pay by the next market day by which time they would have sold a fowl or two or some farm produce to raise the money. Sometimes CHO have to glean from their own meager resources to pay for drugs for one patient or another. Miraculously, the nurses not only get by but also actually succeed in maintaining excellent rapport with the community members. The nurse's main headache is how to balance the issue of sustainability with the exemptions policy. Some people in the community continue to argue that drugs should be given to them for free. Even when they could pay for drugs with relative ease they sometimes refuse to do so.



Still counting the cost of free drugs

When the CHO, like the YZ, is found to owe drug money, she is made to pay before new drugs are issued to her. In most cases the balances that are due to be paid are in the form of drugs held by YZ/YN or CHO, but there are communities that fall into serious debt as they do not have money or drugs. All the same, it must be clearly stated that no CHO or community owes drugs money to the point of being unable to qualify for new supplies, and that is the major strength of the system.

Overall, the management of the drugs has been successful. The average rate of recovery on drugs taken by CHO is 89%, as compared to YN/YZ, which is 83%. This is considered to be a marvelous achievement by the CHO. The major challenge to the Ministry of Health's laudable exemptions policy has been CHO efficiency they are able to reach more exemption cases than they have free drugs to offer them!

What works

Community-based management of drugs can be effectively carried out when the community is involved in such activities with some support. The effective management of drugs requires accountability with regular checks and supervision. With the availability of drugs and FP devices in the community, treatment of minor ailments and FP services are received at their doorstep. The Exemptions Policy is a good idea when patients bear the

cost of travel to distant clinics. For this reason, the policy is continued at Level B sub-district clinics and at Level C—the Nankana District hospital. But when the health service system finances care at Level A—the doorstep or community clinics—the policy is a good idea that fails. Dramatic increases in the volume of health care cannot be sustained with existing resources.

Volume 2, Number 9, 2002

WHAT KEEPS THE WHEELS TURNING?

Communities in the Kassena-Nankana district (KND) where CHOs live and provide health services are distant from health facilities. Compounds in the communities are far apart and no serviceable roads exist to connect them. For community members, walking from one compound to another is a simple matter, but for the health worker who has to provide door-to-door health care, a means of transportation is indispensable to the provision of quick and quality health services. The motorbike comes in handy: it is the office of the CHO, a hospital on wheels. The motorbike is as versatile as its rider—in dew or in dust, health care can still reach the most remote communities and the farthest compounds on a regular basis. When parked in front of the CHC, her local residence which also doubles as the community clinic, it indicates that she is available for consultation. This usually happens in the morning after she returns from compound visitation. A nurse would normally leave the CHC as early as 6:00am and be back by 10:00am to attend to her clients who, by the time she returns, will already have lined up at the CHC.

CHO have speedily mastered motorbiking skills. They meander through a maze of footpaths with admirable agility to bring health care to those who need it most. Although sometimes forced to abandon her motorbike when confronted with hostile terrain, it is now almost unthinkable to talk of a CHO without mentioning her motorbike.

Motorbike riding is now part of the curriculum of CHNs' Training Schools. Training not only teaches basic

riding skills, but covers fundamental maintenance as well. The importance of this component of the CHFP is underscored by the employment of two full-time mechanics by the NHRC and a Workshop Manager who is a General Motors Senior Mechanic. This highly skilled staff ensures proper maintenance of the Centre's motorbikes.

Routine maintenance

Use of motorbikes for community health service delivery is very intensive. Regular maintenance is an absolute necessity if the life span of these motorbikes is to be prolonged. Routine maintenance is carried out based on a scheduled period. This may be based on the number of kilometres covered as advised by the manufacturers or on a monthly schedule drawn up by the garage. During routine maintenance, lubricants are replaced and parts are greased. Engine performance is also checked, loose parts are adjusted, and worn out or damaged parts are replaced.

Preventive maintenance

Weekly preventive maintenance is carried out on the motorbikes when they return from the field. Mechanics check for minor problems that might have arisen during use and include checking engine performance and other minor repair work.



First things first: A community health officer (CHO) checks her motorbike before riding off

Repairs

Repairs are carried out on the motorbikes whether or not the motorbike is due for routine or preventive maintenance. When a part of the motorbike is damaged or worn out, repairs or parts replacement are carried out immediately. If parts are not readily available the motorbike is grounded until parts have been procured. These checks are to ensure that, while on duty, at least the motorbike should never leave its rider on the way. According to the Workshop Manager who oversees the maintenance of the CHFP motorbikes, experience has shown that the Yamaha brand is ideal for the CHO. At the moment the fleet includes Yamaha Escort, YT, Super and AG. Use records have proved that the AG 100 is robust and appropriate for even the most inhospitable terrain that a CHO may confront in her daily service operations.

The period between zero and 1000 kilometres is the most important period in the life of a motorbike. The engine is brand new and its various parts wear and polish themselves to the correct operating clearances. Care must therefore be taken not to put excessive load on the engine for the first 1000 kilometres. With due adherence to manufacturer guidelines, the general routine maintenance procedures for CHFP motorbikes is to replace the transmission oil after the first 500 kilometres. Thereafter, the motorbike goes for regular service every four weeks. Periodic inspection, adjustment and



A large fleet of motorbikes to choose from

lubrication will keep the motorbike in the safest, most efficient condition possible. The motorbike goes for major maintenance after the first 1000 kilometres. During this period the oil is changed and carbon fumes are removed from the exhaust system. If these important points of motorbike maintenance are maintained, a machine *should* last up to five years without major problems. Yet, despite these precautionary measures, motorbike replacement must occur every three years due to weather conditions, harsh terrain, and intensive use.

Though accidents are very rare and fatalities almost unheard of, carelessness has been noted among some of the riders. Some nurses are known for speeding and a few others have been observed deliberately or inadvertently allowing their spouses or relatives to ride the bikes in clear contradiction of the rules governing machine use. This particular offence has attracted a penalty: The privilege of using the motorbikes over the weekend has been withdrawn. CHO are now required to return all motorbikes to the CHFP every Friday evening and pick them again on Monday morning.

Motorbike tyres usually last for up to three months. A 100cc motorbike is the minimum size of machine that can withstand daily CHO use. Less powerful machines have been tried, but have been shown to be uneconomical in the long run. Nine litres of fuel per week is what a CHO needs and receives for her work.



Tough times don't last but tough bikes do

Conclusion

With the above maintenance guidelines, nurses enjoy the comfort of riding their motorbikes with less fear of having major problems with them while they are in their communities far away from town.

Volume 4, Number 21, 2004

WHAT'S IN THE BASKET?

When clients are consulted about health care, most prefer services from a nurse in their community to care at a distant health centre. They claim a client or patient has no identity in the hospital setting, but at the community level services are customized to the needs of the individual or household. Roles and responsibilities are reversed. When community members fall sick they don't have the added burden of traveling to seek medical care; someone will come to their doorstep and attend to them. When a nurse is relocated to the community level, economic costs for seeking health care are considerably slashed, geographical and social distance is bridged, and quality of health services improves. The impact of placing a CHO in a community, even without a health volunteer system to support her, is great. Thus there is strong evidence that supports the CHPS policy of

building CHCs, posting CHO to live in them, and mobilising communities to support their service delivery work. Results of the CHFP clearly show that doorstep and community CHO services represent an important step towards achieving Health for All. The question is, what is it that the nurse does to improve health at the community level?

The mere presence of the CHO in the community is palliative. For instance, experimental findings under the CHFP show that infants exposed to CHO services have 12 percent lower mortality than those not exposed. In late childhood (ages 24-59 months), exposure to two years or more of CHO service activity is associated with nearly a 60 percent *decrease* in mortality among children.

CHO have a wide range of responsibilities while posted to the community. These include, but not limited to: disease surveillance; community mobilisation for health promotion and disease prevention. This is done through routine and special home visits; conducting immunizations for both children, pregnant women and nursing mothers; offering FP counselling and providing FP devices; conducting emergency deliveries and providing technical support to Traditional Birth Attendants (TBA) to conduct deliveries; monitoring the growth of children through child welfare clinics; treating minor ailments such as headaches, abdominal pains, diarrhoea, coughs, colds, malaria, dressing of cuts and sores; referring cases to the next rung on the health ladder; and supervising the work of a network of community health committees which in turn supervise health volunteers.

CHO cannot simply go on community posting with nothing in the basket. As a matter of fact, the Policy, Planning, Monitoring and Evaluation Division (PPME) of the GHS is in the process of compiling a list of essential logistics for CHO in order to have a uniform package countrywide. For effective service delivery the following list, which is by no mean exhaustive, is highly recommended:



It's not what's around the basket that matters, but what goes into it

Essential logistics for CHO***Direct service delivery***

Motorbike, crash helmet, lock

Radio set (dry cells
or solar powered)

Rain coat

Lighting system (electricity/
solar light/gas lamp, lantern,
flashlight)

Wellington boots

Electronic calculator

Ruck sack

Variety of drugs

Drug box

Variety of FP devices

Stationery (Notebooks and pens)

*Where There is no Doctor,
Treatment Guidelines MOH/GHS,
Essential Drug List*

Blood pressure apparatus

Weighing scale

Steel cabinet

Table and chair

Benches

Thermometer

Diary/field notebook

Palpation table

Cold chain equipment

Gloves, bleach

Personal convenience

Bed, mattress

Blanket

Sauce pans

Coal pot/two-burner gas stove

Metal bucket

Kitchen stools

Water storage container

Plastic basin

Living room furniture

Specific needIndispensable for doorstep
health care deliveryEntertainment /stay in touch
with the outside world

Protection

Night activities

Protection

Calculations and report writing

Carrying drugs during
compound visits

Prescribed for CHO work

Drug storage

Prescribed for CHO work

Recordkeeping

Reference books

Taking blood pressure of FP
clients¹Weighing children and mothers
especially FP clientsStorage certain categories of
drugs

Writing

Client/patient comfort during
service delivery at the CHCTaking temperature of children,
especially those with malaria

Recordkeeping

Palpating pregnant women

Vaccine storage and
preservation (six childhood
killer diseases)Emergency deliveries²

One

Two

One set

One

At least one

At least one

At least one

At least one

One set

Even when all these logistics are provided the CHO workload can be crushing. Though ordinarily work does not have to be backbreaking, in the KND CHO have more satellite clinics than required due to the many other research projects being undertaken by the NHRC.

When CHO activities are structured to make nurses work closely with the sub-district, community-based health care delivery becomes less burdensome. Sub-districts for instance, should be responsible for taking vaccines to CHO during immunisation days and returning the cold chain equipment after the activity. CHO do not also have to submit cluster registers as happens under the CHFP experiment. Submission of monthly reports on cases seen should be submitted to the sub-district.

¹Some devices such as the Pill and Depo Provera are known to increase blood pressure; it is therefore necessary to monitor the pressure to avert unpleasant consequences. ²These cannot be offered for free so will have to be paid for as a revolving fund to enable replenishment.

Community health officers

Volume 3, Number 13, 2003

NEED, THE MOTHER OF INNOVATION

Dr. Samuel Kweku Enos has been District Director of Health Services (DDHS) of the Kassena-Nankana District (KND) for the better part of the life of the Community Health and Family Planning Project (CHFP). He discusses his work.

A new community health nurses training school (CHNTS) has been established in the KND to train nurses for the national CHPS programme. As the DDHS, can you tell us how the whole idea came about?

The idea of establishing a CHNTS came about as a result of the need for training more community health nurse (CHN) since the success of the national CHPS programme will depend largely on the availability of nurses. The CHPS concept is basically about putting CHN in communities to deliver health services to the people. But if you look at the capacity of the existing

training schools, it could take about 40 years to produce nurses enough to cover the whole country. But health cannot wait that long. There was therefore the need to find innovative ways of producing more nurses to satisfy this demand. It is thus out this need that the idea came.

You talked of innovations. What is innovative or unique about the Navrongo School?

There are three main things that make the Navrongo Nursing School unique:

- First, the school did not spring up as a government idea but was developed by health workers on the ground and by the people involved in health research in the district.
- The second feature is that the school is a day school. This is something new because all the other nursing schools for CHN are boarding schools. We had learnt that one of the main obstacles the government encounters in setting up new boarding schools is the high cost of feeding and housing. It was therefore thought that the cost of feeding and accommodation could be heavily slashed and the rest of it shared among stakeholders and the direct beneficiaries.
- The final unique feature of the Navrongo initiative is that the school has been built on the foundation of resources from the region. External funding did not play any role for the school to kick off. We did not have to cry out for external financial support from nongovernmental organisations (NGOs) and other organizations. We needed to demonstrate that such an innovation could be carried out at the community level. An old structure, which was not being put to maximum use, was converted into a school and refurbished with support from the



The Navrongo Day-Community Health Nurses Training School—a cost-effective way of training nurses for doorstep health care



The Navro-Pio showing Madam Rofina a large swathe of land for the Navrongo School project

District Assembly, the District Health Management Team (DHMT) and the Navrongo Health Research Centre (NHRC).

By making it a day school, aren't you running the risk of compromising on the quality?

No. We are not compromising on quality at all because there is no evidence that housing and feeding the students in one place ensures the production of quality nurses. On the contrary, we have reason to believe that given the fact the Navrongo School training is based on practical field demonstration the graduates of our school will be better equipped to carry out community work than those from other schools. In a critical analysis, what makes a good nurse is not largely dependent on whether or not she is schooled in a boarding house but rather it is the quality of training that she gets: this is exactly what we are teaching our students. It will also depend on the attitude you put toward work. Our mode of selection is also something to write home about. Students are selected based on district-level sponsorship, which in the long run ensures makes students accountable to the community to which they are obliged to serve after training.

What comments will you make on the nursing situation in the Kassena-Nankana District Administration (KNDA) and the region as a whole? Was there really the need to train more nurses?

Frankly speaking, the nursing situation in the KND and for that matter the Upper East Region is not very bad as compared to that in the southern part of the country. This is as a result of the high exodus of nurses to the outside world which fever does not seem to have caught up with nurses upcountry yet. Also, in terms of nurse-client ratios, the region has an advantage over some of the regions down south. In spite of this there is still a huge gap. For instance, as of 2002, only 18 nurses were placed in the communities in KNDA, even under experimental conditions out of an anticipated 30 nurses who are needed to cover the district fully. With the implementation of the CHPS, the demand for more nurses will far outstrip supply. Traditionally, two nurses per year were posted to the region from the Tamale CHNTS. There is no gainsaying that this is woefully inadequate. There was therefore the urgent need to find innovative ways of producing more nurses to fill in the gap and make health care delivery more accessible and affordable to the people.

What has been the contribution of the traditional authority to the Navrongo School project?

When the idea was mooted, discussions were held with research scientists of the NHRC and the then regional director of health services, Dr. Erasmus Agongo. We then engaged the traditional authority and opinion leaders in the KNDA as we usually do anytime there is a new programme that we intend to roll out in the district. We particularly consulted the Navro-Pio for a permanent site for the school and he offered us a large swath of land. Our hope is that when we get the necessary funding from central government, we will be able to develop the site and put up a permanent structure for the school.

Volume 1, Number 4, 2001

HEALTH ON WHEELS

Ever since the Alma Ata Conference in 1978, Government of Ghana policies have called for placing

trained CHNs in village locations where over 70 percent of the population resides. The cost of constructing clinics is high, however, and CHNs that have been trained for community work typically work in Level B clinics that are inaccessible to most rural households. It is clear that building more clinics and hospitals will not bring health to rural households.

To address the need for partnership in community health, village leaders were approached by the CHFP prior to fieldwork and asked to convene an open forum for the discussion of health service needs.¹ Without exception, every community asked the CHFP to “provide a clinic.” Since funds were not available for construction of clinics in every village, agreements were developed whereby each community contributed labour or materials for constructing a traditional compound (termed the community health compound [CHC]). Once CHC were ready, nurses could be reposted to communities where they lived and worked. Nurses were trained in community diplomacy and health education, reoriented to new management information systems, and retrained in health technologies. Since motorbikes were needed, a training course was provided in motorbike riding and care. These upgraded CHNs were redesignated as community health officers (CHOs) to emphasize their status as upgraded workers. Relocating nurses involved more than constructing CHC and issuing administrative orders. Support systems were developed for assuring that workers had technical, community, supervisory, and peer support, as follows:

Technical support Introducing the CHO model represents an opportunity to improve technical competence through training. CHO were trained in midwifery, a component of care that was missing from the CHN programme. Delivery care and traditional birth attendant (TBA) training are essential elements of community-based care. CHO were also trained in basic



Hospital in a knapsack

diagnostic services, referral, and treatment care. Most importantly, CHO were trained in community entry, diplomacy, counseling, and work planning, all of which represent essential elements of community-based care. Both facilitators and participants evaluated training courses; each course was associated with a report. Training emphasized field-based practical training for problems that workers encounter during the course of village-based service delivery.

Supervisory support Too often supervision is interpreted as a programme of checking on subordinates, policing work, and correcting mistakes. From the onset of CHFP operations, there has been recognition of the need to develop supervisory systems that avoid this mechanical and demoralizing approach to supervision



Community Health Compound (CHC)

¹The CHFP is a collaborative program of field research involving service delivery supervised by the Kassena-Nankana DHMT and research conducted by the Navrongo Health Research Centre.

through a process whereby managers visit subordinates to see how they are working in their own environment and to offer assistance to them. Assistance may involve organizing meetings with community leaders to discuss problems, arranging equipment repair or replacement, advising on health care service activities and needs, and linking CHO with their peers for exchanges and collaborative support.

Community support. A key element of the success of the CHO programme has been to address worker needs for continuous support. Doorstep service delivery can place workers in the middle of community problems that require urgent attention. Moreover a worker who lives in the village may have essential needs that cannot be addressed without community support: Facilities maintenance for the CHC, water for household chores, security needs that require organized support, and diplomatic needs that may call for the intervention of chiefs and elders.

Peer support. Peer support is the process whereby workers at one level of a work system provide advice, support, and leadership to colleagues at the same level of the system. CHO benefit greatly from contact with each other. Carefully planned exchanges can reduce the sense of isolation and vulnerability that goes with living in a village and working alone. Exchanges, organized as meetings, encourage the sharing of information, mutual advice on problem solving, and peer leaderships to improve the quality and efficiency of health care. In



Community health officer (CHO) in the community

recent years, CHO trainees have been assigned to work with experienced CHO. This programme of peer exchange and peer leadership is viewed as an important element of the CHO support system.

Familial support. CHO who are assigned to CHC are removed from relatively comfortable Ministry of Health (MOH) provided housing at the sub-District Health Centre and assigned to villages without moving their families. At the initial stages, CHO were posted to villages without prior discussion with the affected spouses. Establishing familial support has been a critical element to the smooth running of the programme. Meetings to liaise with spouses, hear their concerns, and respect family needs have been crucial to the success of the CHO initiative. Husbands often have no experience in cooking and minimal involvement in child care. Conventional gender-stratified roles therefore constrain the initiative. Moreover, posting a nurse to a village has real costs associated with it: CHO had to buy utensils, flashlights, and personal supplies that turned out to be too costly for affected families to bear. The CHFP therefore developed a “settling-in kit” to provide essential household effects. In keeping with policies of the Ghana Educational Service, a small community hardship allowance is paid to defray the cost of operating two



Community health officer (CHO) being introduced to the community

residences, arranging support for child care, or other family needs.

Conclusion

Placing a nurse in a CHC involves more than issuing instructions and supervising activities. Support systems are required that deal with the impact of this programme on CHO personal lives. Relocating nurses to villages will fail if nurses are left on their own. However, the CHFP has demonstrated ways in which this relocation programme can succeed by supporting workers at the periphery.

Volume 4, Number 22, 2004

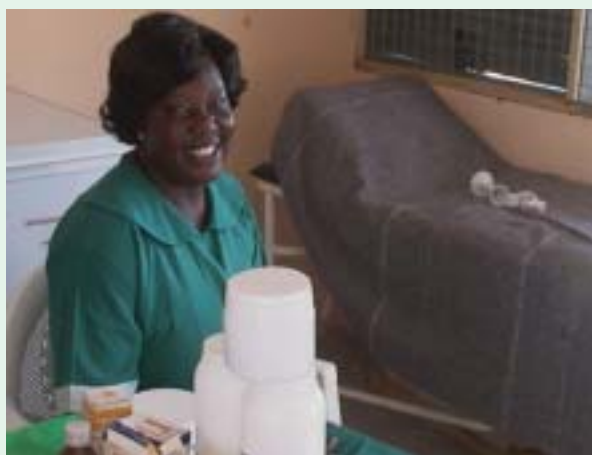
FIRST AMONG EQUALS!

Cecilia Adda discusses her experience as a CHO.

Let's go straight into the heart of the matter. You were one of the first three CHNs to be trained as CHOs. What motivated you to undertake the training?
I was just in the mood to try something different.

Let's have some dates: When did you become a CHO and how did it all begin?

Cecilia Adda, the first among equals. She says a community health officer (CHO) should never run short of essential drugs at her community posting.



I became a CHO in February 1994. We were invited by the CHFP, as CHNs, to take part in a series of discussions about health promotion. During the deliberations we were made to understand that an experiment was underway to find out how well CHNs would function if they went to live among the people in the communities to provide health services. Three of us volunteered. We were given an orientation on how to enter a community and engage members in discussions to improve health. Before we were deployed we were also sent to the hospital ward to observe how doctors were treating patients.

Where were you first posted and how did you fare?

I opened the first CHC in Kayoro. I stayed there for almost two years and I fared generally well. When I was expecting my third child I withdrew briefly to the district level. I stayed in town for about eight months and when I delivered I was sent to open a new CHC in Wuru. I was in Wuru for one year and three months with my motorbike and so I was sent to work in town one more time. I got involved in an accident on my way to Kassena-Nankana east for a malaria awareness programme. A vehicle came from behind and swept me off my bike. I had a fracture in my left tibia. After three months on admission I was up again and joined my colleagues at work. I went on relief duties each time a CHO was on leave. By 1998 I was still not fully recovered to ride a motorbike so I was posted to the Chiana Health Centre. In 1999 I left for school to do a course in midwifery. When I graduated in 2001 I was posted to the War Memorial Hospital in Navrongo. I later served in Kassena-Nankana east as a midwife between November 2001 and August 2002. Then in May 2003 I was posted to Naga, once more as a CHO.

As a CHO would you say there have been any significant changes over the years?

Generally there has been a lot of improvement in the range and quality of services. When we started we did

Read more about Cecilia on <http://www.popcouncil.org/africa/addah.html>.



Even unborn babies speak Cecilia's language

not seem to know what we were doing but through our trial-and-error work, community-based health care delivery has been streamlined. There is better targeting now than it was when we started. I remember all women were included in our registers but now it is only women in the fertility age group (WIFA) who have been retained in the registers. Those in the menopausal age have been taken out. Now we don't have to ask about every woman when we enter a compound. Family planning (FP) uptake has been on a steady rise from virtually zero in 1994. The drugs used to be free of charge but the women did not take advantage of this. Today, they even have to pay money for drugs but they come in their numbers; sometimes the crowds are so huge they are almost unmanageable. We did not have any incentives at all at the start but now CHO get a motivational allowance. But something seems to have gone wrong somewhere along the line. At an earlier time CHO used to meet regularly to compare notes and copy best practices but since resuming as a CHO I have not seen this happen. This is something that needs to be revised and maintained.

What do you particularly like about being a CHO?

I feel good because it gives job satisfaction. No one gives you a work plan. You draw your own work schedule so as to achieve efficient service delivery.

What's difficult about being a CHO?

In the first place you are by yourself there is no one to assist you and there is no one to keep you company. So you are not only always alone but you are most of the time lonely. Then you have the workload to contend with. Being a CHO is a health hazard you hardly have time for yourself. Sometimes I put food on the fire while attending to patients. By the time I realise there is something on the fire it's all burnt. Starting all over again becomes a luxury I cannot afford. So I go to bed on an empty stomach.

Until recently I had no decent roof over my head. Sometimes I have to compete with reptiles for space. It's not that CHO are asking for special treatment. We are just saying that since CHO are in charge of the community's health they need to be alive, healthy, strong and in good spirits to perform their duties. And just when you are about to get a wink of sleep there is a knock at the door summoning you to the scene of an emergency—someone in labour or some child in a fit of convulsion or something serious that requires the CHO's presence to make the difference between life and death. Though we literally kill ourselves just to make others live, no one, especially among our superiors, seems to appreciate the work we do. As a nurse midwife I do domiciliary midwifery because I don't have a delivery bed in my facility, no delivery kit, no forceps, and I have no bleach which is very, very important. I do the deliveries at the patient's home or at the TBA's home. I have to bend down all the time when doing deliveries and that makes the work unnecessarily straining.

Do community members patronize your services?

Yes they do. For instance I organise antenatal clinics every Wednesday and I get between 20–25 pregnant women attending and that is a good number. FP is not doing too badly at all. I have in my register 785 WIFA out of which 72 are FP clients; 50 of them are new. This is not too bad since we have done less than half of the year. The women prefer the “injectable” because they are mostly farmers who work in the irrigation area and they tend to forget things easily. So with the “injectable”

which is every three months, they leave their cards with me. When they come to the market they pass by to ask if their time is due. Thus social distance has been bridged and FP counselling becomes customized and effective.

But something seems to be amiss. And where from this pain lurking behind your broad, generous smile?

I have been expecting some recognition from the CHFP for the work I have done for the Project. When I got involved in the accident not even a tablet of paracetamol was given to me for free. I was terribly disappointed that no one paid any particular attention to my injury. Out of sheer frustration I lost interest in pursuing the case in court; I subsequently withdrew the case and called it quits. There is little wonder that national honours for CHO are being distributed without mention of Kassena-Nankana much less me. But since I have chosen to work as a CHO I have put all this behind me. Even the motorbike from which I fell is now out of use but no one remembers to offer it to me on hire purchase. But I am still in active service and I strongly believe that all the sweat, blood, and tears that we shed to make the CHFP work to the point of becoming a national policy cannot have been shed in vain. The mills of God grind slowly but I know they grind exceeding small. If my reward is on the way I hope to live long enough to receive it. It will be well deserved.

Every cloud must have a silver lining. What has gladdened your heart since you became a CHO?

I remember I used to excel in all service delivery indicators among my peers to be trained as CHO. Once at a meeting at the NHRC I was voted best CHO. As a result I got invited to Accra to make a presentation at the Novotel on the work CHO were doing in the communities. I was a nursing mother at the time but I made it to the meeting with my little child. There were a few hiccups but on the whole things worked out just fine. I think that meeting provided the evidence that Navrongo was feasible and replicable. I felt very proud then I feel proud now.

Volume 2, Number 2, 2002

VIEW FROM THE 'FRONT LINE'

The retraining and transformation of nurses into CHOs and their transfer from expensive, overstaffed, underutilized, and inaccessible sub-district health clinics to purposely built residential CHCs (at the doorsteps of their rural communities) lies at the heart of new efforts by the Ghanaian Ministry of Health to win the battle to provide, "...adequate, efficient and equitable Primary Health Care Services to all Ghanaians." CHO are the "front line staff in this daunting and difficult "battle."

The Navrongo CHFP was designed to investigate the fertility and mortality impact of mobilising two sets of resources for the promotion of primary health care (PHC). The first, "Health at Every Doorstep Dimension," is concerned with bringing CHO into communities, while the second, the "*Zurugelu* (togetherness) Dimension," entails the mobilization of the rich and diverse local "cultural" resources, (chieftaincy structure, social networks, community conventions, volunteer arrangements, etc.).

What works?

Autonomy and confidence. CHNs provide on-site, situational, health care to the communities under their charge. There is ample evidence to suggest that the



Daycare on wheels

greater responsibilities demanded of these CHO—as they work independently and in tune with their local contexts—have translated into a sense of greater autonomy, confidence and professional worth. One CHO was recently cited as saying, “Now I can do things by myself. I don’t go to someone to ask (for advice). Now I do things without panicking. I have built a lot of confidence.”

Situation and relevance. CHO are trained to conduct situational analyses of the conditions that they encounter during their daily rounds and to respond to immediate circumstances. It would appear that CHO welcome the relevant and timely nature of their interventions. One young CHO for example, said that during her training as a sub-district nurse, and throughout her initial posting at a maternal and child health (MCH) clinic, new mothers would come to the clinic well dressed, in expensive new clothes, presenting an aura of relative affluence. The nurses would then give detailed talks on nutrition using visual aids depicting fish and other comparatively expensive sources of protein. Now that the nurses are working in the homes of their patients they see that the women are poor and can’t afford fish so CHO can advise them on what to eat based upon the resources at hand.



Village volunteers constructing a community health compound (CHC)

Supervision and support. All CHO are assigned to—and visited by—a supervisor who periodically appraises technical skills, takes note of welfare concerns and keeps a log of the condition of CHC and motorcycles. The supervisory process is welcomed by the CHO as the supervisors offer support and counseling on a range of professional and personal issues.

What fails?

The importance of social distance. At the pilot stage of the CHFP, there was a view that building upon the strong support of chiefs and elders could be formalized by placing the CHC in close proximity to the chief’s compound. Some chiefs were eager to help by providing land for construction and even materials for the project. Also, there was a view that having a CHO who was originally from the village where she worked would strengthen the project, since she would know families and feel comfortable with this new role. Both initiatives failed: Both men and women objected to the idea that chiefs would know about FP services or possibly be in a position of knowing who was seeking health care. Moreover, nurses who were too close to the village socially could not be trusted to keep secrets. An element of social distance was sought whereby CHC would be constructed in a setting not closely linked with community leaders and CHO would be trusted outsiders.

CHC: construction and location. The most widespread criticism made by the CHO themselves (of their front-line situation) concerns the condition and location of their CHC. The local building materials used to construct the compounds (built as they are by the communities themselves using meagre resources) are not durable and the compounds frequently suffer structural damage, particularly in the rainy season. The comfort and safety of CHO is therefore being jeopardised. One CHO noted that, “some [compounds] are falling down” and another commented that, “our lives are at risk.” A further complaint concerned the location of the CHC and the isolated positioning of some, far from the communities they serve. Several nurses expressed the



CHO facilitative supervisory session

view that they feel lonely and vulnerable to attack. “You are sleeping in the community alone. Imagine if something happens. You will just be crying alone and no one will come!” This sense of isolation was noted by one CHO when she said that initially when they moved into their CHC they, “were given wireless sets to stop [them] from being too bored.” Some of these radios had broken down and had not been replaced. As a result the CHO said that they feel like they are “cut off from the world, not even [just] the country...so [they] don’t know if [they] are going to heaven or hell!”

Workload and welfare worries. The CHFP has identified the “domestic problems of the nurses” as one of the eight challenges faced by the experiment. The daily workload of a CHO is intense. It is not uncommon to hear the nurses suggest that two CHO were required to staff each CHC. As one nurse stated, “when you return from compound visits your bench is full! One [CHO] [ought to] be taking care of the patients at the CHC while the other is on her compound visits.” A CHO supervisor noted that the workload is such that the nurses don’t even get a chance “to breathe.” The supervisor identified a range of potentially serious welfare issues faced by CHO: because of their intense workloads some don’t have time to cook in the evenings and have been known to fall sick and even show signs of malnourishment; access to potable water is another basic

problem as they are often in isolated locations far from sources of safe water; if they are married then there are issues over the care of their children as well as their husband’s acceptance of their profession; some of them start dressing like members of the community and stop wearing their uniforms, therefore making it difficult for them to be identified as nurses.

Community fatigue. As part of their routine work, CHO complete detailed registers, on the health of women of reproductive ages and children under the age of two, within their catchment areas. These registers require the cooperation and time of members of the community. There is some evidence to suggest that this frequent questioning is fatiguing some communities and leaving the nurses frustrated in their daily rounds. As several CHO remarked: “Some families welcome us and some claim that we are worrying them!”; “They feel that we are wasting their time.”; “Even during compound visits some are fed up with us—everyday the same questions! In the rainy season they are busy farming so if they see a motorbike they walk away!”

Practical problems. CHO require greater access to and regularity of supply of basic medical equipment. CHO complain that “First Aid” kits containing bandages, gauze, etc. were not available to them for the treatment of minor injuries. As a result they had to turn down clients and send them to other medical establishments for the most basic of treatments. CHO also did not have facilities for the disposal of used injections, as they had not been supplied with incineration kits.

Conclusion

Evidence from the Navrongo experience suggests that the “front line of the battle” (to provide basic primary health care) is a challenging, harsh and sometimes isolating place. However, being on the front line appears to impart a sense of professional and personal achievement, gained from the knowledge that the battle is being valiantly and appropriately fought. Nevertheless, more concerted and intense efforts ought to be directed into ensuring that the basic welfare needs and technical requirements of the fighters are being met.

Volume 2, Number 3, 2002

THE “PERFECT” CHO

While there will never be a “perfect” CHO, it is helpful to reflect upon the personal qualities of such a worker so that training can orient nurses to the type of person who is most successful in community work. CHNs become CHO after undergoing specialized training to prepare them for life in the community as sole health care providers. Training modules are designed to make CHO as independent as possible and enable them to offer primary health care and FP services to clients with a minimum amount of resources. They are trained to become part of the communities to which they are posted. In order to be successful, they must possess special personal characteristics allowing them to become members of the communities they serve. The perfect CHO serves as a motivating goal that all CHO can aspire to and requires the following characteristics.

Empathetic

Philomena Bemba (fictitious name) graduated from the CHNTS a year ago with distinction. She is young, hard working, and eager to learn. She works at the health centre in town. Already within the first few weeks her work at the health centre is outstanding. Whenever the Medical Assistant is not available, she becomes the natural person to take over, even though there are more

senior nurses and midwives around. Her humility allows her to work well with both patients and hospital staff. She is smart and always neatly dressed. She is jovial and obliging. The common phrase she jokes around with is “People matter more than money!” For this reason, other nurses call her “People.” She is always chatting with her FP clients. Patients like her and ask for her first when they come to the health centre. She has a three-year old daughter, and her husband is away overseas on a three-year course of study. When it is time to choose a nurse to undergo training in order to be deployed as a CHO in a village, she will be the obvious choice. All the senior nurses highly recommend her. There is no doubt Philomena Bemba fits the criteria for highly deployable nurses to village locations.

Competent

The ability to tell the difference between what training does or does not allow you to do is what is referred to here as ‘discernment’. Sometimes, doing nothing helps more than doing something that will put a client’s life in danger. One CHO says, “it depends on what your motives are.” One should do the best that one knows how. Sometimes regulations are a problem. If a CHN knows how to give injections but rules don’t permit it, should she? There are very competent CHN who are able to perform as efficiently as a Medical Assistant or even a Medical Doctor in some cases. A nurse with discernment is a great asset and makes a perfect CHO. She knows when to refer the patient upward in the health system to a service point where the expertise and resources exist to deal with the problems she cannot handle.

Respectful

A CHN must possess that special regard for community leaders, Chiefs and elders, and their way of life. She should not be one to ‘lord it over’ the community because of her control over some health resources and her privileged position. She must possess that ability to merge into the community and hold conversations with women at water sources such as the riverside or at the well. She should be one who can attend village functions such as weddings and most importantly, funerals of



It takes more than training to produce a community health officer (CHO)



A perfect community health officer (CHO) knows the middle ground when talking about culturally sensitive issues

community members—especially women who have lost their children or have themselves died during childbirth.

Adaptable

In light of the above, an aspiring CHO must not be individualistic, radical, quarrelsome, or eccentric. She must believe in the spirit of community, be socially minded, and be able to find the middle ground when she has to deal with culturally sensitive or controversial issues.

Independent

Nurses who are most suited to be CHO are the ones who—at least for the defined period of community residence—have very few social obligations. This allows them to be truly and continuously resident in their assigned communities and remain there for as long as possible to provide uninterrupted services. CHN who are newly married, have too many children or dependents, have business in town, or other trades in conjunction with their work and other encumbrances are harder to keep at the community level. It is important to talk to the spouses of CHN prior to sending them into communities. CHN who are experiencing marriage problems with their partners are the least deployable;

often sending them away tears apart their marriage or causes difficulties between spouses.

Trustworthy

CHO must necessarily be persons who do not have “okro mouths” or what others term “oral diarrhea.” It is important in small communities that CHO keep information about clients’ health, especially their FP choices, in confidence. If a CHN is by nature a person who gossips a lot or “talks too much” about people and is generally known to be untrustworthy with confidential information, she will be diagnosed as unsuitable for CHO work.

Energetic

An ambitious nurse—who is made aware that if she successfully spends the two years of community residence, the DHMT will recommend her for further studies and career improvement—works even more diligently. If they are encouraged that documentation of their work can help them to use the data they have collected and the community experience as material to further their public health careers, they faithfully, dutifully, and with excellence, carry out their assignments.



An ideal community health officer (CHO) spends quality time with her clients, providing personalized and confidential services

Conclusion

CHN need special qualities to become CHO. Above all, they must have something unique that can be brought to bear to community-based health service operations.

Hello there, do you have them; those vital innate characteristics that make CHN deployable?

Volume 2, Number 6, 2002

MOVING UP THE HEALTH LADDER

Introduction

The CHFP is referred to as the Navrongo Project, though at the NHRC there are presently more than five ongoing major projects. The Government of Ghana has adopted findings from the project for implementing a National Health Service delivery initiative known as the CHPS.

Secret of success

The success of the CHFP as opposed to similar programmes in the West Africa sub-Region stems from a unique combination of factors: deployment of the CHO in the village; a system of village volunteerism that supports the nurse; mobilization of traditional authority through village health committees, and support of the political leadership of the district.



Doorstep services at level A—community health officer (CHO) and community health compound (CHC)

Complicated cases

This combination of forces comes into play in all aspects of CHO work. One area of interest that has been discussed by project investigators and the DHMT is the issue of referral. What happens when the CHO is confronted with a situation involving a client that she cannot handle? Such situations may involve seriously ill children, women with complications of labour or FP clients who require specialized attention and need to be sent on to the sub-district health centre or the district hospital. In short, how do patients move up the health system from the community level where CHO and Yezura Zenna (YZ) are outfitted to handle a variety of the most basic ailments, to a hospital which is equipped to deal with complicated cases?

Village Director of Health Services

The CHO occupies a unique position in the village—she is seen as the village director of health services—an extension of the government health authority in the village. She is expected to lead the decisionmaking process as to when and how a patient should be sent upward in the health care hierarchy.

When to say go?

When should a patient be sent upwards in the system, from the village to a health center or hospital? Only CHO, who are trained to recognize cases requiring referral, can answer this question. How promptly CHO refer patients depends on their understanding of what constitutes an emergency and their ability to assess and classify a case as a complicated one. For example, if a CHO has been trained to know that Coca Cola-coloured urine in a patient is a sign of renal complications of malaria then she will effectively advise the parent that the child must go to the hospital.

Special instincts

CHO should be trained to quickly recognize conditions such as severe anaemia, convulsions, dehydration, and the need to refer such cases to the hospital. Training should help them acquire those special instincts that allow a health care provider to tell what is beyond his or



A sub-district clinic (level B) is the first point of call for referral cases from the community health compound (CHC)

her own capabilities or resources, without feeling guilty or incompetent. Awareness of what a prolapsed limb means in a woman in labour or what a fit in a pregnant woman implies, and the urgency with which CHO should facilitate transfer to hospital in each case is crucial to instill through regular training and retraining.

To where should the patient be referred?

The problem of whether a patient should be referred to a health center or a district hospital should be simplified for the CHO. All patients referred by her should go to the next level above her, that is, the health centre to see the Medical Assistant. Admittedly, in some cases, valuable time may be lost if patients are sent to a health centre instead of directly to the hospital. However, it is assumed that health centres will be manned by competent and experienced Medical Assistants and be logistically prepared to deal with many issues such as giving an IV infusion to a severely dehydrated child and cut short the long distance travel that would otherwise be made. A health centre must therefore have the prescribed cadre and resources to be able to handle at least 75% of the cases that are referred by the CHO.

How do we go to the hospital?

This is perhaps the most discussed as well as the most difficult decision to be made in many parts of the world. People who live in communities that have accessible

roads and telephones may take these for granted. In most parts of Ghana, there are no telephones and motorable roads are not commonplace. Dusty roads become muddy in the rainy season and floods wash bridges away. CHO must consult with community leaders ahead of any emergencies about what must be done. In many villages, the people can be so innovative and resourceful that situations that may appear hopeless from a distance may not be completely so. Throughout the developing world major innovations like converting a bicycle into a cart on which a child or a mother can ride and be driven to hospital has been seen in parts of Asia and South America.

Always prepared

Before an emergency happens the CHO should first consult teachers, pastors, Chiefs, and other community leaders and devise a plan for the physical transfer of patients. Sometimes the main issue is lack of money to hire the only village truck to send a bleeding woman to the health centre. The community should be sensitized ahead of time to create a sort of common fund to deal with such situations. An established CHO should alert pregnant women about the possibility of transfer and have them prepare ahead for such possible situations through organizations like mother's clubs. It is possible to get all nursing mothers with children under one year to contribute a chicken each and sell them to create a



A district hospital (level C) is equipped to receive patients from levels A and B

children's transfer fund. The CHO should effectively make the community responsible for how a patient gets to the next referral level. There is always the danger of taking on this responsibility alone. This is not strictly a medical issue, but an issue that must be taken up by Assemblymen and Women in the village, the Village Health Committee, and other identifiable groups and opinion leaders.

The DHMT should provide all referral cases with cards that indicate that a client or a patient has been referred to the hospital. This entitles the patient to priority attention at the referral point. Under no circumstance should a referred patient be treated as a new case and made to start at the beginning of the health system. They must be seen as having already been taken into the custody of the health system from the village level and treated as such. There should be feedback to the CHO at the periphery to help them recognize shortfalls in patient management.

Conclusion

The use of walkie-talkies to solicit assistance in case of emergency would clearly boost efficiency in the health service delivery chain on account of referrals.

Volume 2, Number 30, 2002

"TRUST" AS HEALTH INSURANCE

More than a medic, the traditional healer is a soothsayer who straddles the realm of reality and the ancestral world. He/she assumes the role of an all-round local consultant. His/her services are needed to explain things in the past and forecast the future to guide decisions. His/her prescriptions may result in the need to propitiate the gods for wrongs done or seek guidance for a major decision about to be taken by a member of the compound or clan. This may be done through the pouring of libation or sacrificing a fowl or an animal. Often he/she doubles as physician, surgeon, and pharmacist—providing curative and preventive care. It is this role as spiritual surgeon general which makes the

soothsayer a one-stop health care provider in the community. The system in which he works operates on trust between consultant and client in which payment—whether in the form of a fowl, a ball of tobacco, cola nut, hoe blade, or some such items as are generally available at the community level, but not necessarily readily accessible—is deferred to a convenient date. This system works to perfection not because the herbalist or by whatever name he/she may be known is a celebrated pharmacologist, but because there is always the element of deferred payment which, among impoverished people, is crucial.

The problem

Modern healthcare systems alienate the client because the element of trust is displaced in favour of a health service that requires quick and immediate cost recovery on a "cash-and-carry" basis. Efforts to involve communities in Ministry of Health community health programmes often take the form of cursory visits by outreach workers who exhort community leaders to comply with new policy. To develop a more meaningful and truly collaborative programme, the CHFP adopted a new strategy. It implemented services in conjunction with a system of dialogue with the communities served and used community reactions to guide implementation.

The CHFP successfully reestablished confidence and trust in the health facility among community members.



The community health officer (CHO), a modern-day traditional healer in action



In cash or calf, payment for health care services can always be deferred

It started with a series of consultations with community leaders, social networks, and ordinary community dwellers to seek guidance about a community-based health care delivery system that increases geographical and financial access a health intervention strategy that works, not from the perspective of the provider but from the point of view of the beneficiary. Community members, acting as consultants, abhorred the lack of empathy associated with facility-based health care. They demanded services that are socially accessible. In designing the CHFP experiment, trust was built into the new system by bridging the social distance between service provider and clients. Chiefs, elders, and lineage heads were so involved that CHO knew that care could be provided with payment deferred. The extended family system would ensure that payment was forthcoming because every family head understood that failure to honour this debt would endanger the concept of health for all. Clients soon learned that trust was an important part of the CHFP service system. *“Now if the nurse [CHO] tells me something and I forget I can ask her about it when we meet at the market place,”* states a client. When asked what prevents women from asking the nurse at the hospital they reply, *“But they are not even friendly!”* In the hospital setting you have no identity, but at the community level, services are tailored to individual

specific needs. Above all, there is total trust and confidence between service provider and client.

A man from an isolated community said: *“When she [the CHO] comes what she talks to us about is our health. A lot of women have not been to the large places [cities] and some of us have not also been to the large places before so how can you and your wife handle your children? Secondly she also tells us how we should give birth and it will help us in our lives.”*

Compound visits and face-to-face interaction—the hallmark of CHO work—have been very much appreciated. This approach achieved the objective of establishing credible health services by linking FP to a regimen of care that people accept and respect. A woman from a isolated community disclosed, *“At first measles has been killing our children and high fever has also been killing them. If it had been at that time you came, you wouldn’t have seen us—we would have been at a funeral house. Since she has come we haven’t seen children dying again. We are happy with the nurse.”*

System of deferred payment

When things started working out this way, it was not difficult to draw parallels with age-old traditional health care delivery strategies that were still widely available among the people. Like the traditional healer, the redeployed nurse gave free consultation to clients and when drugs were prescribed she was the one to dispense them from her village supply kit. When her clients and patients did not have money on hand to “cash and carry,” payment was deferred till the next market day when the extended family could pay. This is what worked and this is what is being replicated in all districts country-wide. Why establish elaborate modern community-based mutual health systems that require much start-up capital when a more traditional, cost-effective, and efficient system exists? Solving population health problems should no longer be the sole responsibility of health institutions. The goal of any innovative health promotion is to enable people to increase control over and to improve their health. Community members and local groups must participate

in open discussions and feel empowered to act on those health concerns that they jointly define.

Conclusion

Health insurance is often perceived as a western concept. Health planners assume that insurance is costly; requiring government subsidy and extended donor support. In fact, because systems of trust already exist, the best way forward is to build trust in the community health care system. This should generate interest from governments, NGOs, and international organizations interested in new and innovative approaches to the difficult issues of health care financing and access.

Volume 3, Number 3, 2003

AKULPOKA'S DAILY BREAD

Lawrencia Fanga is a CHO stationed in Doba. He is married with children. He was one of the very first to be trained as a CHO to start the Pilot project of the CHFP launched in the KND in 1994. Fanga discusses his work.

Doba is a small community south of Navrongo central in the Upper East region. It shares borders with Kandiga in the east and Nayagnia in the north on the Navrongo-



Lawrencia Fanga moving out in search of those who need her services



Health messages are tailored to the needs of both young and old

Bolgatanga road. Its operational total population is 3,751. Children 0–11 months are 150, 0–23 months are 300, 0–5 years are 750, WIFA is 750, and expected pregnancy is 150. Almost half of the population is illiterate and their main occupation is farming. However, a handful of women are into petty trading.

As a CHO, I live in the community. They come for health services at any time. My schedule includes offering FP, child welfare, antenatal services, school health inspection, health education talks, home visits, deliveries, post-natal services and outreach.

I work 24 hours around the clock! As early as six o'clock in the morning sick people and FP clients arrive in the CHC for treatment or counseling. After attending to all of them I leave for home visits. Before I leave I indicate on the notice board the names of the compounds I am visiting and the names of the compound heads so that in case of an emergency or when a supervisor comes around he or she would know where to trace me. When going out on compound visits, I carry a rucksack containing the following items; cluster register which bears the names of women and children of that cluster, FP register containing the names of FP clients, treatment book for minor ailments, antenatal cards for registering new pregnant women, FP cards and identity cards for new registrants. In terms of drugs I carry paracetamol and chloroquine, both in tablet and in syrup; FP devices such as Depo-Provera, the oral



Pushing health indicators up by bringing temperatures down

contraceptive pill, male and female condoms. I also carry with me some health education posters and leaflets for health education talks.

When I get to the cluster where I am to work, I move from one compound to another. I work a minimum of seven compounds a day. When I enter a compound I ask about the health of people in the compound and then ask the landlord for permission to start my work. I introduce myself and the work I do in the community. I then proceed to talk based on my observation of the compound. I also ask them about their health needs. If I can solve them I proceed to do so, if not I refer them to the nearest health post. I treat people and give women their repeated FP doses and also sell FP devices to those who request them. I usually return to the community health compound at about 2:00 pm to find more sick people and FP clients waiting for me. Instead of retiring and taking a rest like the hospital staff who close after their shift, I continue to attend to patients as I prepare food for lunch which ends up to be my supper. I often retire between 8:00 and 10:00 pm. It is not only quite normal but also actually a regular practice for people to come and wake me up at midnight for medical attention.

The work is very challenging and interesting. What motivates me is the results that I see the number of preventable diseases and needless deaths that I help prevent in the community. When someone falls ill or

when there is an emergency, I am there! I am the Community Director of Health Services. But it is not all roses. One of the biggest problems is that people want me to use my motorbike as an ambulance to send patients to the hospital. Another problem is with drugs. When people buy drugs they are not able to pay for them on the spot even though the drugs are reasonably priced to make them affordable. Self-medication is also a regular phenomenon and patients often fail to go for full treatment. The work of a CHO has really helped me. I have gained self-confidence and I am now also able to plan my own work schedule.

Volume 4, Number 11, 2004

WITH A 25-HOUR DUTY CALL, THERE'S NO TIME TO IDLE

Florence Akavure is a CHO stationed at Chiana Kaliveo in the West zone of the KND. She lives in the community where she is assigned to deliver compound-specific preventive and curative health care. Akavure discusses her work.

The operation area is divided into seven clusters with a population of 4053 inhabitants. As a CHO I have been provided with a motorbike for compound visits and other activities. Each cluster has a register for recording



Florence Akavura tutoring a pupil on community-based health care delivery

data. All the clusters are visited once every 90-day period. My duties are aimed at improving primary health care at the community level. Specifically, I treat minor ailments at the clinic, most commonly malaria, diarrhoea, and common cold. I offer FP counselling and services, and run both antenatal clinics and child welfare clinics where the growth of children is monitored by ensuring that they take all the immunizations such as Polio, Bacillus Calmette-Guerin (Tuberculosis) vaccine (BCG), Hip Hep, and Measles. Children who default are discovered during compound visits as are women who default in FP. This is perhaps the biggest advantage of home visits—you discover problems and find solutions to them.

Health education is a major part of my duties since I am to help prevent people from falling ill in the first place. I educate people on proper waste disposal, clean environment, nutrition, and the importance of a well-balanced diet—emphasizing that a well-balanced diet does not have to be expensive because even at the community level there is enough food that can be combined in a certain way to get proper nutrition. I urge them to construct good and well-ventilated homes with large windows to enable fresh air to flow freely. Above all, I entreat them to patronize health facilities at the CHC-level and to visit the hospital anytime they are ill.

Before I set out on compound visits in the morning, I usually draw an itinerary indicating where I am going and how to locate me. Just before I leave I conduct a routine check of my motorbike and put it in fine shape. I check my drugs stock level and replenish them if necessary. I then ride off prepared for all eventualities. Besides these day-to-day activities, I run three antenatal clinics every month. As a trained midwife in addition to being a CHO, I conduct deliveries. This means more work for me even though it is a blessing to the community members. In reality I have no time to rest, not even on Sundays. While I am at home, people call in for services especially FP clients. Even while I am stirring my evening meal I break in between to provide services.

When I started as a CHO it was very tough for me. I have never stayed in a community alone without my

family. At the community level I have been given all sorts of titles such as Director, Doctor, Midwife Nurse, Medical Assistant, Professor, and so on. This shows that my activities in the community are very much appreciated. I am very proud of that; it's one of the things that keeps a CHO going.

Despite the fact that there are no social amenities such as electricity in order to watch TV, or telecommunication services to connect to the sub-district hospital, I still enjoy the work. With the type of experience I have gained, I am sure I can work in any hamlet in Ghana.”

Beatrice Azigedah is a CHO stationed at Kanania in Kassena-Nankana west. She discusses her work.

I serve a population of 3396 in six clusters. I work 24 hours a day! Some of the logistics I have been given to do my work include a motorbike, cluster registers, and drugs.

Before I start my daily activities I leave a notice on my door directing people to where I can be located. I visit between 7–10 compounds a day. When on compound visits I look for WIFA. I register pregnant women, palpate them, and administer immunizations to



At the durbar grounds in Kanania, to air is human

them and also to children ages 0–24 months. I organise child welfare clinics to monitor the growth of children and to ensure that they are fully immunized. When I enter a compound I enquire about everyone's health first. I then attend to emergency cases, if there are any. I do health education, counsel couples on FP, and offer contraceptive services to those who request them. I also identify cases that need hospital attention and refer them. Infrequently I come across a labour case and I deliver the baby or assist the TBA with the delivery. I discovered that the delivery box of the TBA in my catchment area was well equipped so I usually assisted her with deliveries.

I normally return home late in the afternoon. I continue to see patients and clients at the CHC. In the night I go on to treat patients and attend to FP clients who report. Sometimes I am called at night to attend to emergency cases such as labour or snakebite. Those that I cannot handle I refer immediately to the sub-district hospital.

At the end of every month I submit a report of my activities for the previous month to the DHMT. I realise that CHO work is very important because it helps capture non-attendance to antenatal clinics, FP, or immunization defaulters. I also meet FP clients in the comfort of their homes and discuss FP as part of our general conversation about health.

Strictly speaking, the work of the CHO is very tiresome—especially when you are alone in the community. I also miss town activities and facilities such as electricity, television, and water that I could have been enjoying. I miss home. I miss my family and friends. I have two homes—the one with my family and friends and the other where my patients and clients are. I have to spend a lot more money running the two homes than I would have spent on just one. That makes things difficult sometimes. In the night there is interruption in my sleep as patients wake me to attend to emergency cases especially a woman in labour! When duty calls, I just have to respond.



A CHO—bedridden with a complicated knee injury after falling from her motorbike in the line of duty

Volume 4, Number 19, 2004

WHO NURSES THE NURSE?

A CHO discusses her work and her accident.

As a CHO you are supposed to be living in a community providing health care. Can you explain your presence here at the district hospital?

I have been attached to the Maternal and Child Health Centre in the District Hospital in Navrongo. I am convalescing from a knee injury following a motorbike accident I got involved in about half a year ago. I am beginning to learn how to walk again so my posting here is to give me the opportunity to exercise my knee as I begin the slow and painful journey to full recovery.

Give us an insight into your work as a CHO.

I have been a CHO for four years. I started at the Gia community in 2001. After one year I was transferred to Gaani where I stayed for two years before I was sent to Kayoro. Only six months into my assignment at my new station I got involved in an accident with my motorbike.

Is that the first time you have been involved in an accident with your motorbike?

No. That was the second time. The first one occurred on September 19, 2003. A cyclist crashed onto my



Two supports to lean on—her son on the right, and her crutch on the left

motorbike when I was riding. I fell off the motorbike and got bruised but not seriously injured. I was treated and discharged. I stayed at home for only three days and went back to work. Then as fate would have it, on December 5, 2003, I was involved in another accident. I left for the field at about 10:00 am to supervise health volunteers who were administering Polio vaccines to children. I had hardly moved out on my bike when a man suddenly crossed my way. I had to apply sharp brakes to avoid hitting him. I was moving slowly and tooting my horn to warn pedestrians because there were a lot of people on the road, but all of a sudden here was a man right in front of me and I thought I had to do all I could to avoid running over him. In the process I fell and the motorbike fell on my knee. I did not know I was injured until I tried to lift myself up. I could not. I was helped by those who were around and rushed to the Chiana Health Centre where I was referred to the district hospital and from there to the regional hospital in Bolgatanga. After an x-ray of the injured knee, I was referred to Tamale Hospital, 200 km away to see a bone specialist.

It was in Tamale that I was told it was a torn ligament and an operation was required. I returned home, prepared, and went back for the operation which was performed on January 9, 2004. I stayed in the ward for four weeks before I was discharged but I could not walk because of the pain and the stiffness of the leg. I

have been at home now for five months and you can see that I am now only beginning to learn how to walk again, with the aid of the crutch.

We sympathize with you for what has happened. How does all this make you feel?

In fact I don't feel bad about it. I feel I have done my duty. As a CHO I live and work with community members, mainly trying to stop them from falling sick in the first place and also treating those who fall ill. If I injure myself in the course of performing my duties, I take it as an occupational hazard. Moreover, as a motor rider, I expect things like this to happen. Though I feel bad sitting at home doing nothing, I am looking forward to being able to walk well again and to start work afresh.

How did your community take the news of your accident?

The community was reportedly thrown into grief and disbelief. The Chief and some of his elders visited me personally at the hospital. I am not surprised that they felt very bad about my accident because I had already built good relations with the community members and trust between service provider and client had also been established. Kayoro is probably the farthest way and most isolated community in the KND and as a nurse midwife I did more than just attend to their minor



In more active times: Felicia administering immunizations to a child



Even in great pain, Felicia maintains her infectious smile that keeps her clients at ease

health needs. I also conducted deliveries in conjunction with TBAs. I helped prevent deaths that would have resulted from pregnancy and child delivery complications.

Is there anything special that needs to be done to recognize the difficulties involved in CHO work?

The Ministry has no policy for picking up the medical bills of health personnel. That is already bad enough. The individual is left to her fate, which is what I am going through now. The district assisted me with some little money for transportation and promised further assistance but there is nothing else to expect from the Ministry. Take this scenario: *A nurse is sent to the remotest parts to serve. She gets injured in the course of her duty, not during her leisure time. She foots all her medical bills, and when she recovers she is expected to go back to the community to continue to serve and to put up her best. Is this your idea of fairness?*

I have no idea. But frankly, how can some of these issues be addressed?

The CHO work is a new service delivery initiative. As it is scaled up across the country, there is the need for the

policy makers to review service delivery guidelines and set humane conditions of service for CHO taking into consideration their peculiar circumstances and risks.

Who nurses the nurse at the community level?

When a CHO is taken ill and she can walk or ride she reports to the nearest clinic and seeks treatment. But I must reiterate that the nurse pays for all the drugs. If the nurse cannot move on her own it is the community's responsibility to assist. In my case, it was the community that took me in the market truck and sent me to the nearest health post.

When do you hope to fully resume work as a CHO?

You know CHO work is not a sedentary business. A CHO seeks the people at their homes and brings them health care. The main mode of doing CHO work is the use of the motorbike which, in rural northern Ghana, is one of the most valuable pieces of equipment for delivering health services. I kick start the bike with my right leg. Since I am injured in the right knee, I don't know how long it will take for me to regain the strength that I need to kick start a motorbike. That is what it all now depends on—my being able to start the motorbike. But things are not too bad as at now.

How did your family cope with the situation?

The family was distraught. You know I am a single parent with three children, two boys and a girl. I also contribute to the bread basket of the extended family. So when I went down everyone was alarmed and I could feel it. But they all did what they could. They lifted me, cleaned me, and coaxed me to eat. Gradually, I was able to take a few steps. Now everyone is recovering from the shock and the smiles are coming back on the faces of my children and family relations and I am happy to see that.

Conclusion

May the smiles remain there for a very long time.

Health aides

Volume 1, Number 6, 2001

BAMAOKO, IS IT IN MALI?

The Bamako Initiative is a regional programme sponsored by UNICEF that aims to develop low-cost, accessible, and sustainable health care by organizing health committees and volunteers for health services and backstopping their work with logistics and training. A key theme of the programme is establishing cost recovery for essential drugs and organizing logistics for resupplying village pharmaceutical kits. While the Bamako idea is appealing, the practical details of how to organize the programme have not always been thoroughly developed in settings where it has been tried. As a consequence, implementation of the Bamako Initiative has faced various operational problems.¹ The Community Health and Family Planning Project (CHFP) has sought ways of making Bamako work. At the heart of the strategy is the observation that Kassena-Nankana society is rich in cultural resources. Yet, until recently, these resources have not been effectively used for community health service delivery. To address the gap between traditional social institutions and community health services, the CHFP has developed the *Zurugelu* (togetherness) dimension of the Navrongo Experiment. *Zurugelu* strategies mobilize cultural resources of chieftaincy, social networks, village gatherings, volunteerism and community support to undergird the CHFP programme. Making Bamako work has various elements in the Navrongo system:

¹In Ghana, the Bamako Initiative has never been adopted as official policy. However, elements of the Bamako concept have been promulgated with the aim of developing low-cost volunteer services.



Traditional leaders can be health leaders

Leadership. The *Zurugelu* system is based on the observation that traditional societies have a hierarchy of traditional leaders who command respect from the people whom they govern. Furthermore, traditional social support networks exist in rural communities that can be effectively mobilized to promote health care. Specifically, there are two components to the *Zurugelu* approach: the *Yezura Zenna* (Health Aide or YZ) component and the *Yezura Nakwa* (Health Committee or YN) component. YZ represent a cadre of volunteers from the rural community that are selected by the traditional leadership to assist with local health service delivery. Volunteers are not on their own; they report to YN who maintain a stock of supplies of essential drugs, manage accounts and a revolving fund for purchasing drugs, and coordinate volunteer work with other CHFP activities. YN also mediate in disputes among volunteers or between volunteers and other members of the



Yezura Zenna (YZ)

community, and represent the programme at community functions.

Volunteerism. The YZ component is premised on the notion that communities can actively and effectively participate in improving their own health status. The YZ concept has resonated with communities since they have been accustomed to utilizing resources within the community that hitherto had been limited to the services of traditional healers. The YZ component has resulted in wider coverage of health services, greater access for the community to health service provision, and community pride in their ability to contribute collectively to the improvement of their health. The YZ volunteer works in tandem with the local Community Health Officer (CHO) by delivering basic care, providing preventive health information, and referring cases to the CHO for more intensive curative health needs that may be required.

Training. Both YN and YZ are trained in various aspects of health care provision. YN are trained in record keeping and the management of accounts. YZ training includes the treatment of ailments (malaria and diarrhoeal diseases), the provision of family planning (FP) information and supply of contraceptives, nutrition information, immunization promotion, drug

management and record keeping. In addition, YZ are relied upon by the community and the surrounding health service institutions for data gathering and report writing. As such, it is essential that the YZ volunteer is reliable, available and committed to the important tasks at hand. YZ training is conducted in day-long sessions every 90 days.

Technical supervision. A team of CHFP supervisors has been assigned to the task of community liaison, community organization, and field supervision of the *Zurugelu* programme. These supervisors represent an incremental staffing configuration of the programme that is not included in the normal MOH/Ghana Health Service staffing pattern. As a matter of fact, professional community workers are crucial to the success of volunteer operations. They deal with the problems of volunteer turnover, disputes between YN and YZ, community organizational problems, and other issues that are difficult to predict but essential to resolve in the course of making volunteerism work.

Incentives. YZ and YN are not paid, and demands for compensation and MOH jobs are to be expected in the course of any volunteer scheme. It is important to structure community rewards in the form of strategies for enhancing the prestige and recognition of volunteers. Training can serve as an incentive, and should be conducted on a regular basis. The bicycles provided to YZ are highly prized and represent the most direct form of compensation to volunteers even though a volunteer may not own the bicycle until he/she has used it for a minimum of one year and a half.



Yezura Zenna (YZ) conferring with Community Health and Family Planning Project (CHFP) staff



Replenishing depleted stocks is a major headache

Logistics. The official drug exemption policy does not work in the context of the Bamako Initiative; free drugs to children under 5 and pregnant women cannot be sustained. However, a “cash and carry” policy of charging cost recovery fees sustains the flow of resources. Special procedures are required for supervisors to maintain stocks at the district level and sustain the flow of drugs to communities on a “demand pull” system for replenishing supplies.

Conclusion

The CHFP has demonstrated ways of mobilizing traditional cultural resources for supporting and delivering primary health care. In doing so, it provides a practical example of how the Bamako Initiative can work in a rural, traditional, and isolated district of northern Ghana. Implementing the Bamako approach requires a programme of assembling and training community committees, in close cooperation with traditional leaders. It involves convening regular public gatherings for soliciting community opinion about the programme. Finally, it involves developing comprehensive links between the volunteer system and the formal health care system so that all community health activities, including the Bamako component, function as an integrated system of primary health care service delivery.

Volume 1, Number 5, 2001

ZURUGELU: TOGETHERNESS FOR HEALTH

Ghana is widely acclaimed as a country with rich and complex sociocultural institutions. Utilizing these institutions in a programme of health care delivery can greatly improve the effectiveness, sustainability, and relevance of health care operations. This principle has been demonstrated by the Navrongo CHFP which has established a collaboration between the key social institutions and the community health care delivery system: This system of care has involved connecting the traditional social organizational system, with the Ministry of Health (MOH) structure, and the political system. In the local language, this is called the “*Zurugelu* Approach.” *Zurugelu* is the Kasem word meaning “unity is strength” or “community togetherness.” Thus, a *Zurugelu* Approach represents an attempt to marshal resources from various societal stakeholders. More specifically, however, the *Zurugelu* Dimension of the CHFP refers to all efforts that incorporate traditional and community institutions into the design of the project.

The *Zurugelu Dimension* was born from a practical need to incorporate cultural sensitivity into the project design, and was fuelled by the recognition of numerous cultural resources in Kassena-Nankana society that had not been tapped by the MOH programme. In many communities throughout the Kassena-Nankana District (KND), traditional systems of village leadership and



Traditional leaders attend a community durbar



Yezura Zenna (YZ) on his daily rounds

social organisation play fundamental roles in fostering volunteerism as well as in influencing individual behaviour. The *Zurugelu Dimension* of the CHFP has mobilised these effective and well-established traditional institutions for the planning, organisation, and management of FP and primary health care. The CHFP operational plan for the *Zurugelu* scheme involves mobilisation of the following village components: chieftaincy and lineage system, social networks, YN (health committees), YZ (health volunteers), traditional communication, and non-traditional communication. By integrating the organisation of service delivery into the existing social system, the CHFP has attained legitimacy, respect, and cooperation from local communities.

The primary aspect of community entry and mobilisation involves an understanding of the traditional structure of authority. In Kassena-Nankana societies, Chiefs and elders command a great deal of respect, and serve as primary decision makers for all important village affairs. Knowledge of and cooperation with this authority has allowed the CHFP to conduct affairs appropriately and to facilitate the generation of understanding, organizational preparation, and active communication from community leaders. Traditional leaders are key players in legitimising, launching, and sustaining various initiatives, thus their support is essential for project success.

Yezura Nakwa. Unit Committees (UC) are well-established, community-level political structures, and are responsible for the actual implementation of activities that have been sanctioned by the Chiefs and elders. In order to carry out its duties, the UC constitute Implementation Committees (IC) among interested community members and also coordinate peer networks, which are traditional associations that join youth, men, and women together for various social and communal activities. The CHFP has mobilized this traditional system of task leadership through the Paramount Chief and his Council of Elders who established an IC for health, termed YN (health welfare committee).

YN are now responsible for health administration in their respective communities and serve as internal supervisors for village volunteers known locally as YZ. YN stock and supply drugs to the YZ, oversee the maintenance of bicycles, settle community disputes regarding YZ, and develop the scheme for pricing, cost recovery, and compensation. As elders and respected members of the community, the YN serve as valuable sources for information dissemination, community motivation, and assessment of community actions and reactions.

Yezura Zenna. The most fundamental aspect of the *Zurugelu Dimension* is the use of community volunteers as primary service providers. The CHFP developed the



Students act out a drama for a film

YZ programme in response to the shortcomings of the now defunct MOH Village Health Worker (YHW) scheme. This new approach involves the use of local community members to serve as YZ or volunteer health aides. Selection of the YZ is the responsibility of the community. Initially, Chiefs, elders, and other community members nominate permanent members of the community who they feel are reliable and trustworthy, and who have also demonstrated a keen spirit of volunteerism. The final adoption of YZ requires the consensus of the community; this is extremely important, as community support is critical for the successful execution of YZ responsibilities. Additionally, if any problems arise during the YZ's course of service, which the YN cannot settle, Chiefs and other community members are consulted to mediate the dispute.

YZ are trained in various aspects of primary health care provision and are utilised to improve accessibility to low-cost essential drugs. Their roles involve treatment of minor ailments and ambulatory care for certain illnesses such as simple malaria and diarrhoea. YZ are equipped to dispense the following drugs: Paracetamol, Chloroquine, Piriton, Multivitamins, Aludrox, and nonprescription contraceptives such as condoms, and foaming tablets. In addition, YZ are responsible for the dissemination of information regarding, nutrition, immunization, and FP. They are relied upon to gather accurate and complete data and to write descriptive reports. In order to effectively carry out their duties, YZ are provided with bicycles, which also serve as incentives for participation. Possession of a mode of transportation assures community recognition and prestige; both represent a form of compensation. Both YN and CHFP staff regularly supervise YZ.

Traditional communication. Another critical factor of the *Zurugelu Dimension* is utilisation of the community's traditional system of communication and mobilisation. In Kassena-Nankana communities, Chiefs hold traditional meetings called *durbars* in order to discuss issues of common concern or to rally participation for various community activities such as farm labour or development projects. Recognizing the

effectiveness of this approach, the CHFP has adopted the use of *durbars* as a means to establish credibility and community support, as well as to serve as a forum for discussing project activities. *Durbars* are usually well attended by various community members, including Chiefs, sub-Chiefs, elders, youth, Assemblymen and women. The occasion involves speeches by community leaders and CHFP staff, and is made lively by drumming, dancing, and songs about health.

Nontraditional communication The CHFP has also introduced a nontraditional form of communication, which the communities have whole-heartedly embraced. The drama troupe is a very important part of the CHFP design. The troupe acts in films that are screened in communities during the evenings. Films of particular interest are on issues such as "Male Involvement in Family Planning" or "Female Genital Mutilation." The scripts are written by a CHFP staff member and acted in either of the two main languages of the District by students of Saint John Bosco's Training College in Navrongo. Every effort is made to ensure that the scenarios, dialogue, and characterization are a slice of Kassena-Nankana way of life. Though the subject matter is rather serious, it is subtly woven into a humorous and entertaining drama. Communities have indicated substantial interest in and appreciation for the films, as large crowds often gather and watch the films intently. At the end of every film show, a discussion session is held so that community members can ask questions or raise issues of concern. CHFP staff and a resource person such as a medical doctor, nurse or midwife are available to respond and offer clarifications. Though the logistics involved in film showings are often difficult, the overall impact of this initiative appears to be positive.

Conclusion

Implementation of a viable health service delivery scheme in rural, traditional Ghanaian societies requires support from traditional community leaders and networks. Additionally, modes of communication and task implementation must be adapted to suit the existing community structure. The CHFP has made a significant effort to incorporate each of these factors into its project

design. Collectively termed the *Zurugelu Dimension*, these efforts offer the project a unique system of implicit accountability and sustainability. The CHFP experience has demonstrated that indeed, “cooperating together is strength.”

Volume 2, Number 17, 2002

WHERE THERE IS NO NAME FOR “DOCTOR”

“A bisem.” This is a usual greeting by a Yezura Zennu (YZ) as he enters a compound to offer health services to members of the compound. The term is derived from the *Zurugelu* concept (coming together and doing things together). This is a traditional system of getting things done for individuals and communities. This concept was introduced to replace the VHW Scheme introduced in the 1970s by the MOH. This concept failed because volunteers were not properly monitored, resulting in their overstepping the scope of their work. Equipped with basic data in simple primary health care, a YZ goes on compound visits offering health services to members of a community to which he/she belongs. Owing to the fact that he is a volunteer, he is not assigned compounds to visit in a specified period of time as is done with CHOs. He works three days a week; this enables him to attend to his personal activities to earn income.

Yezura Zenna selection

The process for selecting YZ is very rigorous and meticulous. After several consultations between the CHFP and community members, a YZ is chosen by a Chief and members of his community. In some cases, the selection is done in collaboration with formal political structures at the community level such as an Assemblyman or UC members. Selection of the YZ is based on certain criteria such as having a spirit of volunteerism, dedication and honesty, a willingness to stay relatively permanently in the community, an ability to ride a bicycle, and being functionally literate. (Although functional literacy has eluded many a YZ and



The Yezura Zenna (YZ) is a solution looking for problems

some communities have stark illiterates serving as YZ and who, surprisingly, are doing well.)

Right from the outset, it is made known to the candidate that the job is a purely voluntary service. First he/she is introduced to the community at a durbar for community acceptance or rejection. If the person proposed is accepted, the District Health Management Team (DHMT) in collaboration with the CHFP team of the Navrongo Health Research Centre (NHRC) then trains him for two weeks.

Content of Yezura Zenna training

During training, the YZ is taken through environmental sanitation, health education, personal hygiene, water sanitation, nutrition, maternal and child care (including immunization), treatment of minor ailments, counseling on FP, use of FP devices, and simple bookkeeping techniques. The YZ also goes on practical attachment in the consulting room of a hospital. After his training, a durbar is again organized and the YZ is presented to the community as being ready to start work. Here, he is told all the do's and don'ts of his/her work in the presence of community members. He is not to give injections, handle or dispense antibiotics, and should not provide ambulance services but rather, refer patients to the nearest health facility.

Refresher training

Subsequently, three-day training workshops are organized every quarter. The content of these workshops is drawn from problems encountered by the YZ or identified by supervisors in the field. Sub-district supervisors who are DHMT staff organize the workshops in collaboration with the training coordinator of the NHRC. YZ are taken through effective conduct of home visits, proper organization and submission of monthly reports, and any other topic the supervisor and the training coordinator deem appropriate. Certain YZ are trained to distribute oral contraceptive pills to women. During refresher training sessions YZ are given the opportunity to share their experiences and problems in order to learn from each other.

Yezura Zenna working tools

YZ working tools include drugs, a drugs storage box, a rucksack for transporting drugs, two notebooks for recordkeeping, and a bicycle as his means of transport. At a durbar to present the items to the YZ, decorum is strictly respected—the project first gives the items to the Chief, who in turn hands them over to the YN, a health committee usually made up of five members. The YeN then hand the items to the YZ in the presence of community members. The YZ is admonished to work hard and not disappoint the community and should use the bicycle to do the work for which it is given—health delivery. Since YZ work is voluntary, an appeal is made



Training the “Village Doctor”



The “Village Doctor” providing doorstep service

to community members to assist the YZ to function effectively by helping out on his/her farm during the rainy season and also helping with building or renovation work on his/her house when the need arises. The YZ is then given an opportunity to speak if he/she so wishes.

Yezura Zenna scope of work

YZ give treatment to anyone with minor ailments such as malaria, headache, abdominal pains, diarrhoea, etc and refers patients to the resident nurse in the community known as the CHO or the nearest health facility where necessary. If there is no one needing treatment during that visit, the YZ gives situational health talks. Other functions of the YZ include:

Community mobilization. The YZ does not only seek the health of his community members, he is also a social mobilizer of people to undertake communal labour when the need arises. When there is the need to build or renovate a Community Health Compound (CHC), construct a ventilated improved pit latrine, keep the surrounding of a borehole clean or undertake any other health-related community project, the YZ educates community members as he goes on compound visits on the need to undertake a particular project. He also actively participates in executing the project.

Outreach clinics. The YZ also assists the CHO or the sub-district outreach team to run Child Welfare Clinics. His role is to inform mothers by passing the information of an impending clinic to all sectional heads of his community so that they will in turn make

announcements on the eve of the clinic when all members of his community are supposed to be at home. The YZ also reminds mothers of impending clinics as he does his compound visits. At an outreach clinic, he weighs children and records their weight on their Road-To-Health Cards. He also educates mothers who have defaulted on the need to attend outreaches. Children of mothers who have persistently defaulted are identified by the YZ who informs the CHO, who, in turn, traces the child/children for the necessary immunizations. *Disease surveillance.* The YZ also serves as a link between the community and any health facility within the community. He alerts health authorities of any strange disease in the community for action to be taken before an epidemic occurs.

Referral. For many families, the YZ replaces the traditional healer as the first source of health care. YZ are trained to recognize cases that they are not qualified to treat, and to refer these cases to CHO or sub-district Health Centres.

Volume 2, Number 18, 2002

WHAT KEEPS THE VOLUNTEER GOING?

In spite of their limited professional training and restricted scope of activities, health volunteers enjoy considerable respect for their role in health service delivery at the community level. In earlier times this respect from community members was responsible for pushing the VHW to assume roles he was not qualified for. Under the CHFP, the role of the volunteer has been reviewed and a strict regime of supervision has been instituted to guide the “village doctor” in his daily activities.

Supervision and monitoring are tools used to ensure that things go as expected and that YZ are not left to operate entirely on their own. Supervision and monitoring are done at six different levels: sub-district, DHMT; the CHFP; the community resident nurse

(CHO); the YN, Health committee; and the entire community where YZ operate.

Supervision entails checking the YZ's two record books: one for patient treatment records and the other for drug records. The treatment book is checked to see the number of patients treated for the month, drugs used and if there are referrals of patients or FP clients. The supervisor also looks at the drug records to see how many drugs the YZ has received from the YN, when the drugs were collected, total cost of drugs received, expiry dates of drugs, cash on hand, and how much has been paid to the YN. This is to ensure that the YZ does not keep money at home but pays the YN on a regular basis to enable them settle their indebtedness and collect more drugs from the project office.

The monitoring role of community members of the YZ's work is vital because the YZ are chosen by them and live among them. Community members may report any misconduct on the part of the YZ to the YN, CHO, and supervisors from the sub-district, DHMT or project staff or simply make known their impressions about the YZ's activities at durbars.

Limit to volunteerism

The volunteer concept has generally served communities well. Yet, like any human endeavour, the YZ concept has its share of problems. When communities are approached to select someone to train as a YZ, some Chiefs single handedly choose their relations to be



Project supervisor checking Yezura Zenna (YZ) drug stock level



Health committee undergoes training—gaining the tools to supervise the work of volunteers

trained. In such cases the YZ does not see himself as answerable to the health committee or community members. Then, as time goes on, he does not meet the community's expectations. There are instances when a YZ squanders drug money and cannot pay the YN, or absconds with funds or drugs, or refuses to go out into the community, thus bringing health service delivery to a stand still. When this happens, discussions are held with the Chief and his community to find a way of resolving the problem.

Some people accept the YZ position with ulterior motives (such as being absorbed into the MOH work force some day) and when this is not forthcoming after working for some time, they start agitating and making demands. They give all kinds of excuses to supervisors for not working during a particular period. There is a limit to volunteerism. When a YZ is tired of working, sometimes he informs the community to get somebody to replace him; but there are instances when he is removed by the community because he does not meet their expectations.

Sustaining volunteerism

The YZ concept can be sustained by concerted efforts from the DHMT, the District Assembly, the traditional leadership, the recipient community, and the volunteers themselves. At the DHMT level, the programme for YZ training should be strictly followed to get the volunteers together every quarter. The training programme should

be reviewed periodically to include current health problems in order to put YZ on alert all the time.

The DHMT should figure prominently in the discussions to select volunteers, in order to let YZ know that they are going to work with the sub-district management team and not with the CHFP project or the NHRC. This will curb misplacement of loyalties militating against sustainability of the concept. Supervision has always been part of the duties of DHMT team members. YZ should be supervised as regularly as CHO are.

The community should see the volunteer concept as their own initiative to help themselves and should therefore be involved in consultations to select a volunteer for the community. Logistics such as raincoats, Wellington boots, and torchlights should be provided by the community to assist the YZ to work effectively even under unfavourable weather conditions. Above all, community members should contribute money to set up their drug fund, which can be used to pay for drugs at the district medical stores. This will lead to accountability.

With proper training, monitoring and strict supervision, communities can play an active part in health care delivery, and bring health services within their own doorsteps. With the YZ around, community members no longer have to travel long distances for the treatment of minor ailments. In addition, the activities of quacks are also held in check.



Community members looking intently into Yezura Zenna (YZ) activities

Clearly, there is a limit to volunteerism and people cannot volunteer forever. For various reasons the spirit of volunteerism and the enthusiasm with which people work declines over time. The spirit of volunteerism may die either because a YZ accepted the assignment with an ulterior motive that is not being realized. There may be some commitments that conflict with YZ work or a more lucrative opportunity has opened up elsewhere. Others simply get tired of being a volunteer. Female YZ are more dedicated to their work than male YZ, although it is more difficult for communities to nominate females as YZ. Female YZ are more meticulous, sell more drugs, and submit reports more promptly than their male counterparts.

Conclusion

One clear advantage is that the YZ concept has allowed community members to be active participants in health service delivery instead of being passive recipients. The regular training has made the YZ a multi-purpose health worker first to his family and his community at large. YZ have reported that they find prestige in their work. YZ are happy to put smiles on people's faces, and that probably is what keeps them going.

Volume 4, Number 6, 2004

THE RIGHT ROAD TO BAMAKO

Although many countries in sub-Saharan Africa have different cultures, delivery of national FP programmes is relatively uniform: clinical services are developed for referral services and the provision of long-acting contraception; community-based distribution (CBD) is developed for non-clinical methods. It is widely assumed that making FP services available in community locations will inevitably lead to increased use of contraception and reduced fertility. To this day, the CHFP of the NHRC tests the relative effectiveness of alternative strategies for achieving increased contraceptive use and low fertility. In keeping with the spirit of Health for All, facilities, staff, and medical

supplies utilised in the experiment are resources routinely available throughout the region and all study areas of the KND have the same density of health care providers per population, the same level of training, and the same medical supplies. Thus, the CHFP experiment tests whether these alternative strategies for utilising these resources at the community level are effective.

The *zurugelu* intervention involves mobilizing traditional social institutions in health delivery and planning, as called for by the UNICEF-sponsored "Bamako Initiative", which promotes the idea that managing health care resources and providing revolving funds for primary health care drugs and services through community volunteers can be a sustainable means of achieving Health for All. Village health committees, termed YN, were established in collaboration with chiefs, elders, and other community opinion leaders. The YN oversees a cadre of health volunteers named YZ, who form the backbone of the *zurugelu* approach. The YZ main task is to sell the CHFP idea to the community, particularly men who exert considerable influence over women's mobility to seek health care. YZ receive two weeks of initial training and quarterly refresher training. They visit households to talk about hygiene, child immunization, and other health issues, and to make it known that they are available for basic treatment and referrals. They have significant health resources at their disposal, including Paracetamol for febrile illnesses,



Though paved with good intentions the road to Bamako is full of twists and turns



Contraception is not against conception; it only allows women the privilege to determine when to have babies

Chloroquine for malaria, Aludrox for abdominal pains, and multivitamins, but they do not have antibiotics or vaccines. Instead, they provide referrals to the clinics and help organize immunization campaigns. Another important element of the *zurugelu* intervention is the *durbar*, or community gathering, which is traditionally used by chiefs to mobilize community action on some issue of common concern. *Durbars* provide an effective means of communicating project messages to communities, establish the integrity of the project, and build community support.

A health service mobilisation intervention tests the effectiveness of improving access to CHOs by reassigning them from sub-district clinics to community-constructed residences, known as CHCs, and equipping them to conduct door-to-door health services. CHO are trained for two years, paid a monthly salary, and provide a wider range of health intervention options than YZ.

In the combined intervention area, the *zurugelu* and CHO approaches are pursued simultaneously. This intervention tests the premise that the *zurugelu* and MOH mobilization interventions are complementary and synergistic, combining the implicit accountability and sustainability of the former with the relative advantages of professionalism in the latter. In the combined treatment area, close collaborative links have been established between the YZ and the CHO.

A study which dealt with the observation that CBD has not been subjected to a careful experimental trial has

been carried out in the KND of northern Ghana. The study examined the net impact of training and deploying YZ to distribute the pill on overall contraceptive practice and choice of contraceptive method. A total of 14,234 women (individual women or women interviewed more than once) ages 15–49 from 1993 and 1995–2000 Navrongo Panel Surveys were included in the various statistical analyses which accounted for age composition, educational attainment, and other background information. Several issues were analysed such as comparison of current contraceptive method use between the survey years and the determinants of current use of a contraceptive method by type of method. For the purposes of the study, the impact of CBD was considered to be defined by the incremental effect of YZ service delivery in the YZ areas versus YZ without pill CBD. In the combined areas, the impact of CBD was measured in terms of adding pill distribution to the community regimen that already involves CHO service delivery activities. In short, the findings are as follows:

- Unadjusted 1997 baseline prevalence rates for pill and other modern contraceptive use were the same in CBD and non-CBD areas of YZ and combined areas. Prior to intervention, pill use prevalence was uniformly low in both areas, comprising 1.3% of all women in non-CBD areas and in communities where CBD was subsequently introduced. Slight changes are suggested by the increase to 1.5% in distribution areas, while pill prevalence declined slightly in non-CBD areas.
- CBD exposure appears to have also impacted current use of modern methods other than oral contraceptive pills. Prior to intervention, use of other modern methods was 7.9% among women in YZ and combined cells, regardless of whether or not they were in an area assigned to receive subsequent CBD services. In 2000, prevalence of other modern methods dropped to 6.3% in areas where YZ distributed pills, and increased to 9.3% in areas with no CBD services.
- In the CHFP CHO and comparison areas, the prevalence of the use of pills and other modern

methods changed very little between 1997 and 2000 within each cell. In CHO-only, the prevalence of pill use was 0.7% in 1997 and 0.8% in 2000, while pill use declined from 0.5% to 0.4% among women in the comparison area.

- Use of other modern methods also remained constant within each of these areas. In all experimental areas, use of methods to delay or avoid pregnancy not classified as modern (withdrawal, rhythm, or other traditional methods) declined from 1997 to 2000.

A re-examination of these relationships with a statistical method of analysis that assesses the significance of the conceived effect of CBD within the agenda of the CHFP experiment was conducted. This analysis assessed the chances of using a pill, other modern method, and non-modern methods (withdrawal, rhythm, or other traditional methods), relative to not using any method, among women exposed to CBD services while taking into account the duration of exposure to CHFP experimental treatment. The results show that there is an unexpected net *negative* effect of CBD on pill use and other method use. The chances of pill use are reduced by 33%; the chances of other modern methods of contraceptive use are diminished by 23% per year of exposure. This suggests that pill CBD in this context has significantly reduced the efficacy of the CHFP, most prominently the method that the intervention was designed to promote. This inconsistent effect cannot be explained by background characteristics and reproductive motives of respondents in the statistical analysis, or bias associated with the geographic distribution of the initiative.

In general, results from this study show that the effectiveness of the Navrongo combined service strategy is diminished by volunteer CBD. This may arise when CBD makes contraception convenient, while constraining choice to pills and condoms. Where CHO outreach is combined with male community mobilization, without associated CBD, virtually all adoption and use is injectable and NORPLANT® based. Findings suggest that resolving perceived social costs of FP may be more

important to fostering the adoption and use of contraception than improving geographic accessibility. If convenient service providers are offering constrained contraceptive options, CBD can actually diminish overall programme impact by diverting choice to methods that are associated with low acceptability and continuity. Where demand for FP is emerging and fragile, the importance of developing socially appropriate service strategies is particularly acute.

Volume 4, Number 10, 2004

BICYCLE WITH A FLAT TYRE¹

In the KND, a volunteer on a bicycle symbolizes a new commitment to volunteerism that improves upon past failed programmes. Volunteers are equipped with bicycles, knapsacks, and basic drugs for treating minor ailments. Health committees provide supervision and leadership that were lacking previously; logistics operations ensure the regular flow of drugs through a sustainable programme of support for community leadership. Volunteers are trained and deployed, ensuring the best possible quality of care with referral training to assure links to CHOs and health centres. Community participation is developed with outreach to chiefs, training for councils of elders, and *durbars* for all. Taken together, this operation is called “The *Zurugelu*” approach to community mobilization. The operation works: volunteers are deployed, equipped, and appreciated; *durbars* occur in regular intervals, and health committees function as they should. Most international agencies, policymakers, and health providers believe that mobilizing community volunteer operations work will improve health.

¹Based on NHRC report “Child Mortality and Health Seeking Behaviour of Primary Health Caretakers in the Kassena-Nankana District” by Philomena Efua Nyarko, Rofina Asuru, Brian Pence, Patricia Akweongo, Philip Adongo, Joyce Ablordeppey, Abraham Hodgson.



Some bicycles are ready to be deployed...

Results of the Navrongo Experiment challenge some of these assumptions. Success in getting volunteer bicycle wheels rolling may have failed to improve health. The bicycle initiative has a flat tyre that may be beyond repair:

- Children in the second year of life experience double the mortality rates that they experienced prior to intervention in areas where volunteers alone provide services,
- On the other hand, children aged 2 to 5 years experience about a third less mortality after intervention relative to rates before intervention in communities with a CHO. In the later years of



...others are grounded with a flat tyre, and though they do no harm they do no one any good either

childhood, the benefits are even greater—rates are roughly half pre-intervention levels.

These results indicate that the presence of the health volunteers (YZ) in the communities may be having a detrimental effect on child health. For example, the rise in mortality after YZ are posted could be attributed to the fact that when children become sick, their mothers first consult the YZ (as the project intended), whose services are more convenient and less expensive than those of the clinic. As part of their responsibilities, the YZ are expected to provide basic medicines such as Paracetamol, and to refer children to a clinic for such things as antibiotic therapy. In the second year of life, acute respiratory infections (ARI) are an important cause of morbidity and mortality in the district. In such cases, mothers may be receiving ineffective treatment from the YZ rather than being referred to the clinic, leading to increased mortality among children in this age group. But, this is ruled out by training, supervision, and rules such as the one that YZ are not allowed to provide antipyretics to children. Research has determined that they are abiding by this rule. The second possibility is that mothers may not be responding to referrals by the YZ at all, or in situations where the mothers may heed the referral advice of the YZ, they may not treat it with the urgency that it deserves. Research turned to questions that could not be answered without investigation: Why is the CHO so much more effective than the volunteer? Why has the *zurugelu* approach failed to reduce childhood mortality when the nurse in the community works so well?

A study has shown that both nurses and volunteers are respected in communities, but nurses change traditional health-seeking behaviour while volunteers do not. Several important features of household health decisionmaking can lead to fatal delays in seeking effective care. For example:

- Familial obligation diminishes mother's health-seeking autonomy. Men, compound heads, and mothers-in-law have much to say about whether or not a sick child will be provided with health care. Only about a quarter of all mothers can make their own decisions about seeking health care.

Azuma Asoko, health volunteer for Zuo community, Kologo



Volunteers may be dedicated but lack the credibility, skills, and service that mothers seek for their children

- Home treatment owing to resource constraints. Most children are first treated at home, and many do not receive the appropriate care when this occurs. The cost of treatment is the main reason for delay in seeking formal health services.
- Social customs cause delay in seeking treatment. Mothers are expected to consult with husbands about possible supernatural causes of illness. Soothsayer consultation, herbal treatment, and other actions can seriously delay the process of seeking professional health provider assistance.

CHO have their impact on health by substituting services for these sources of delay. In cells where CHO are posted, women have more autonomy in seeking health care for children than in other cells. Accessible CHO services empower mothers to seek care for their children. Through household encounters, children receive prompt treatment that would require permission otherwise. Costs are reduced, and sometimes deferred, permitting families to share costs when resources are available. CHOs substitute modern services for traditional healing, providing a meaningful alternative to traditional care.

But the volunteer's bike has a flat tyre by comparison. Even the most dedicated volunteer lacks the

credibility, skills, and services that mothers seek for their children. The health-seeking study suggests that they do no harm, but they do no real good either, apart from their role as FP promoters among men, and their work as facilitators of CHO services. YZ do little to offset familial, resource, and social barriers to parental health seeking behaviour. Health volunteers should be community health promoters, not family health care providers.

Volume 4, Number 15, 2004

WHEN WHAT WORKS FAILS

The Navrongo experiment, first launched as a pilot in 1994, tests the mortality and fertility impact on primary health care of mobilizing untapped resources and shifting the locus of care delivery. Under the experiment's *Zurugelu* (togetherness) dimension which seeks ways of involving communities in the planning, delivery, and supervision of primary health care essential drug revolving funds are established to sustain the replenishment of drugs and local operation costs. The first supply of drugs procured by the CHFP serves as the basis of the revolving fund. Funds generated by prescriptions are passed on to supervisors who are responsible for replenishing supplies. Health volunteers



Project staff assist Nabio-Batiu health committee resolve disagreements under the tree

Box 1

The communities of Nabio-Batiu choose their health committee, which in turn chooses its Chairman. The health committee dismisses its Chairman over missing drugs. The Chairman refuses to quit and there is a stand off! Seemingly small problems became major. The YN Chairman kept the drug box and the key, and yet 120,000 tablets of Paracetamol were soon missing. He and the YN Secretary were asked by the community leaders to refund the cost of the missing drugs. When this couldn't be readily resolved, the Secretary was dismissed and the YN Chairman was cautioned. Later, when condoms disappeared, and 200 additional Paracetamol tablets couldn't be accounted for, the YN dismisses the Chairman and tells community elders to drop him as a health committee member altogether. At an elders meeting, the YN Chairman was instructed to give up the drug box but he refused to comply. A new YN Chairman was appointed and his name submitted to the CHFP but he could not begin his functions because the drugs were still unaccounted for. Besieged by his community, the former YN Chairman claimed that he did not object to losing his YN Chairmanship and giving up control of the drug box, but he would not accept being dismissed as a health committee member altogether. The elders and the health committee disagreed, claiming that committee members who had engaged in misconduct could not continue on the health committee. Ultimately, the community resolved the issue and the YN Chairman was replaced without further incident.

called YZ dispense drugs that are maintained in a community pharmaceutical kit managed by a health committee called YN. The YN manage accounts and replenish YZ supplies. Supervisors, in turn, check accounts and replenish YN pharmaceutical kits. The YZ and CHO service operations generate resources for the DHMT to use at the Central Medical Stores for restocking supplies.

This system for managing the revolving fund has generally worked well but there have been exceptions. Box 1 recalls when something went amiss with the drug management system in Nabio-Batiu, a small community

in the *zurugelu* cell where volunteers provide preventive and curative health care.

While health committees typically work, they sometimes fail. The Nabio-Batiu incident is an example where procedural safeguards of checks and balances failed. When a health committee manages a box of pharmaceuticals, extraordinary attention must be directed to supervisory support and community diplomacy. Too often, volunteer schemes are viewed as a substitute for investment in management, professional community liaison, and training. But the Nabio-Batiu example demonstrates the need to combine professional leadership with volunteer action. The fact that volunteers are unpaid does not make their work less complex. The health volunteer collects drugs from the DHMT and gives them to the health committee Chairman who maintains records and secures storage. On demand, the health volunteer and health committee Secretary seek supplies from the stock, and replenish funds as drugs are sold. This requires planning and anticipation of the need for new stocks. Either the DHMT must supply the Chairman, or there must be provision for the committee to obtain drugs from district stores. This is a process where relationships, integrity, and leadership are crucial. Breakdowns can occur that are difficult for communities to resolve.



What works is for the nurse to reside in the community and reach all immunisable children

In the Nabio-Batiu case, the health committee and elders had a point in dismissing the health committee Chairman, but they possibly went about it badly. There is probably more to this story than meets the eye. Perhaps political and clan issues made the health committee toughen their stand against the Chairman, or such problems led to his indiscretions in the first place. When drugs are provided to communities, it is necessary to anticipate such problems, and to develop strategies for resolving clan conflicts, social discord, and political polarization.

Isolating volunteers from CHO does not work. The CHC, where nurses are relocated in the rural areas, has become the symbol of efficient health care delivery at the village level. As a one-stop health service delivery post at the community level, a trained paramedic equipped with a motorbike, basic drugs, and equipment for primary health services is relocated from a sub-district clinic to the community. Throughout the KND communities have become partners in health care delivery. Once a community embraces the concept of a CHO relocating to their midst, it becomes its responsibility to provide a

dwelling place for the nurse. Also, the nurse becomes a technical supervisor of the health committee and volunteers. When YN shift their focus from the drug kit to health mobilization, their support becomes crucial to the programme and prospects for conflict diminish. For example, if a CHC is not readily available, which often happens, a new one has to be built. Resources are mobilised locally, and health committees can coordinate this process. Health committees can support the work of nurses and drugs can be maintained at the CHC. Community discord is reduced if volunteers are health mobilisers, and health committees support care rather than maintain stocks of drugs. Once the nurse is in residence she becomes part of the community. In turn, the YN can assume responsibility for taking care of her; ensuring her safety, security and comfort. By using the YN and YZ as mobilisers, what usually works always works. But when communities are involved in managing drugs, what usually works sometimes fails. This notwithstanding health committees have a crucial role in supporting the CHO where CHO are posted to the community.

Impact and implications

Volume 3, Number 1, 2003

A NEW BEGINNING

Dr. John E. Williams, Co-Investigator, Community Health and Family Planning Project (CHFP), discusses his work.

That the CHFP has made remarkable progress in finding feasible means of re-introducing a Primary Health Care (PHC) system in rural Ghana cannot be disputed much. Even the die-hard skeptics will admit that the project has made some headway in bringing healthcare closer to the doorstep of the people who often need it most—the poor rural dwellers, who incidentally constitute the majority of our people.

The Ghana Health Service (GHS) has recognised the innovations, which were rigorously tested in Navrongo, as the way forward in addressing many of the nagging problems of our health-care system. The Community-based Health Planning and Services (CHPS) Initiative is a major shift in paradigm for a health service which for a long time had become bogged down by inefficiency, stasis, and lack of dynamism. CHPS should provide a new way of doing things and with it should come some welcome freshness and hopefully, endless opportunities for health managers who are willing to innovate. This may start to sound like a fairy tale with the ending “and they all lived happily ever after.” The question is, “is this the end?” Have we done all that can be done with the opportunities we’ve had? Probably, we would need to examine our dear CHFP again as well as ourselves, and ask the questions that need to be asked and answered before we start to pat ourselves on the back and say goodbye to one of the cornerstones of the NHRC. The saying goes that every good thing has an end. Whether we like it or not, the CHFP will not continue forever and will one day breathe its last.



Dr. John E. Williams—anything up his sleeve?

A critical examination of the CHFP, with its objectives in mind, reveals that it has demonstrated quite well, a new context within which services can be delivered. What about the content of what has been delivered so far? Can we say we are satisfied or is there room for improvement?

The CHFP has played host to several teams of district health workers from all over the country, all of them with the sole purpose of coming to see the ‘Navrongo Experiment’ firsthand. At debriefing sessions at the end of these visits, our CHOs have often been commended for working hard under difficult conditions and making genuine efforts to do their best for their communities. However, one often gets the feeling that the exposure we give our guests demystifies their feelings about Navrongo and probably, their rather high expectations about top-notch services being delivered here in the Kassena-Nankana district (KND). I can even



The challenges are daunting but health just cannot wait

imagine them saying to themselves that we can do better than this!

Yes, so we have shown that it is feasible to deploy CHOs into remote community locations. We have also shown that volunteers can be deployed to assist the CHOs successfully if supervision is adequate and comprehensive. Our community mobilisation efforts are also well known. Are we willing to reach within ourselves to admit that there is unfinished business, without causing others to suspect that we could be harbouring base motives? Maybe we just want the CHFP to go on and on and on until the end of time, so that our salaries and allowances will keep rolling in!

Methinks our motives are more honourable than that! In the life of this project, many ideas have surfaced, not all of which have seen the light of day as far as implementation is concerned. One of these “bright” ideas is the incorporation into the project of an emergency obstetric care programme.

Following the International Conference on Population and Development (ICPD) in Cairo in 1994, all countries were encouraged to make efforts to provide integrated reproductive health services. One would not just be vigorously promoting family planning (FP) without being concerned about the other reproductive health needs of couples and individuals. The CHFP has equipped CHOs to provide some curative health care for

minor ailments, run under-fives clinics, provide FP counseling and services and run antenatal clinics. The CHFP has also spawned the Female Genital Mutilation Project which seeks to minimize the practice of FGM, which is prevalent in some parts of the KND. It is clear therefore that the CHFP reproductive health component has not been too narrow. A lot more remains to be achieved however.

Several years ago, a plan was drawn up to introduce an emergency obstetric care programme (EOC) to address the issue of poor obstetric care in the district. The efforts of the CHOs and volunteers have resulted in a massive improvement in antenatal clinic attendance by pregnant women in the district. This has however, not been translated into an increase in the proportion of deliveries in the district supervised by trained health workers since most pregnant women still deliver at home with the assistance of compound members. This is particularly worrying when one considers that maternal and neonatal mortality rates in the district are still much higher than national averages. We envisage a programme that will involve a massive educational campaign targeted mainly at first-time pregnancies. Our expectation is that the momentum built among first time parents will be carried on to subsequent pregnancies. The programme will require communications equipment and appropriate transport to enable prompt referral and evacuation of cases, which require higher levels of care. Training of the CHOs and midwives at the Health Centres and the War Memorial Hospital will be stepped up. Other facilities at the various institutions, for delivery and resuscitation will have to be provided.

There are other areas, which will have to be addressed to ensure that the whole concept of the CHFP has been properly assimilated into the health delivery system. Presently, the CHOs relate very well with the sub-district health apparatus, from where they are supervised. However, linkages to other parts of the healthcare delivery tree have not been explored. This is necessary, not for administrative purposes, but to ensure continuity of services and enhance efficiency. Some patients who are treated in hospital may require follow-ups at home and this can be easily incorporated into the

CHO's schedule. For example, patients who are receiving treatment for tuberculosis often default in their treatment once they complete the intensive phase of their treatment and are discharged home. Placing the continuing phase of their therapy under the supervision of the CHOs could improve completion rates. The same arguments can be made for home-based care of people living with HIV/AIDS (PLWHA). Home-based care of PLWHA is now in vogue, because the chronicity of their condition is such that they cannot always be on admission in Hospital and if care can be provided at home for minor problems that develop, then the number of hospital visits can be drastically reduced. This is another scope of work for the CHO that requires further attention. The Ghana AIDS Commission is presently trying to commission research into finding socially acceptable models for home-based care for PLWHA.

The CHFP has really made great strides, which can be attested to, for a long time to come. It behooves us all to try to fill in the remaining gaps, which have opened up with time, to ensure that the people feel the real benefits of "health for all."

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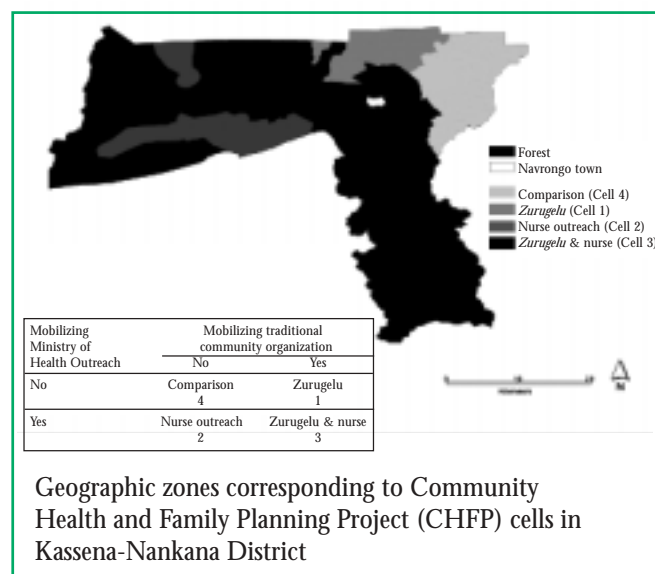
BREAKING GROUND, PLANTING SEED, AND HARVESTING RESULTS

Results from Phase I of *The Navrongo Experiment* on developing a new health delivery approach were more than just encouraging. They defined the broad outlines for raising the quality and efficiency of health service delivery in rural communities. The CHFP has origins that date as far back as 1977 when the Ministry of Health (MOH) promulgated a policy that called for PHC services at "Level A:"

Because most disease problems that cause the high rates of illness and deaths among Ghanaians, are preventable or curable if diagnosed promptly by simple basic and primary health care procedures, the major objectives of the [MOH] are to extend coverage of basic and primary health services to the

most people possible during the next ten years. In order to provide this extent of coverage it will be necessary to engage the cooperation and authorisation of the people themselves at the community level. It will involve virtual curtailment of the sophisticated hospital construction and renovation and will require a reorientation and redeployment of at least some of the health personnel from hospital based activities to community-oriented activities. (Health Policies for Ghana, p.1 National Health Planning Unit MOH, Accra, 1997.)

The design. The CHFP has two experimental dimensions: i) The "*Zurugelu* Dimension" involves mobilizing existing traditional social institutions of chieftaincy, lineage, village governance, and community communication for primary health care. In the local language, *Zurugelu* literally means, "unity is-strength." In this context, it stands for "togetherness." *Zurugelu* volunteers, termed *Yezura Zenna* (YZ) have been trained and deployed in half of the district; ii) The MOH outreach dimension is designed to make existing health service resources community-based. In all, 16 Community Health Nurses were retrained and redesignated as Community Health Officers (CHO), and deployed in village locations in half of the district where they move from compound to compound and provide health education, immunization, treatment of





One of the first community health officer deployed in the field

minor aliments, FP counseling and services. Since the mobilization of *Zurugelu* and MOH outreach resources can be undertaken independently, jointly or not at all, the two dimensions of the experiment imply a four-cell design. Each of these four cells corresponds to a catchment area of a "Level B" sub-District Health Centre (see figure above). Cell 1 is an area utilising the Village Volunteer or *YZ/Yezura Nakwa (YN)* concept which consists of mobilising traditional cultural resources at the periphery. Cell 2 involves posting Community Health Officers (CHO) to Community Health Compounds (CHC) and mobilising existing MOH resources to support community health care. Cell 3 is a combination of both CHO and YZ/YN in health service delivery. Cell 4 is a comparison area where usual clinic-based services and the usual MOH outreach clinics are conducted.

Operational results. A pilot phase of the CHFP demonstrated mechanisms for achieving the long-standing goal of developing community health care by: i) consulting communities and approaching them to construct CHC where nurses could live and provide health services; ii) retraining community health nurse and redesignating them as CHO to function as community-based health workers; iii) equipping CHO with motorbikes and training them to provide compound-to-compound services in regular work cycles;

iv) supplying an initial allocation of essential drugs to be distributed on a cost recovery basis; and v) developing administrative support systems for village services to include health system supervision, management information systems, community liaison, communication, and logistics support.

The *Zurugelu* arm of the experiment utilizes a new and comprehensive community-managed programme of volunteer health service delivery. This involved approaching chiefs and elders and constituting village health committees, training committees in the requirements of managing volunteer effort, guiding committees in the selection of volunteers, training volunteers in recurrent training sessions, and providing community health committees with simple-to-use village worker-based management information system (MIS) for the control of essential drugs and the monitoring of the service performance of volunteers. Close supervisory liaison procedures are designed to develop community-based accountability for volunteer service activities.

Coverage for health services has greatly increased. For the first eleven months of 1997 (January to November) eight CHN that have been redeployed to work as CHO, each in defined catchment communities in the Central sub-district of the KND, managed a total of more than 10,000 outpatient cases. Over the same period of time a fully functional health centre in the Kassena-Nankana East sub-district, with a Medical Assistant and a full complement of health workers totaling over twenty, saw less than 3,000 outpatient department (OPD) cases. The CHO, in addition, visit on the average seven compounds a day where they provide compound-relevant and compound-specific health education. Since the average number of people in a compound is 10, it means the CHO is able to provide health messages to about seventy people each day. A single CHO can therefore outperform an entire sub-district health centre.

Demographic results. The project has had both fertility and mortality effects:

- **Fertility.** In Cell 1, the project has had an impact on fertility in the first year, but this effect was



Child survival became a crucial issue in the Community Health and Family Planning Project (CHFP)

temporary, suggesting that couples will adopt contraception when *Zurugelu* activities are launched but that sustaining programme effects requires more comprehensive community health care than can be managed by volunteers alone. In Cell 2, there has been no fertility effect up through the year 2000. This suggests that the role of *Zurugelu* activities is a necessary component of the programme. In Cell 3, where services are combined, the Total Fertility Rate (TFR) declined by about one-half of one birth in the first project year and declined by an additional 0.1 birth subsequently. This effect is significant and observed in all age groups in contrast to patterns observed in Asia and Latin America. Early results also suggest that limited mobility of women and lack of autonomy to seek services requires strategies for doorstep service delivery. When the *Zurugelu* approach is combined with CHO community care, the programme works.

- **Childhood mortality.** It is too early in the project to make definitive conclusions about survival effects. When preliminary results are examined, findings demonstrate a need for continuing health research and strategic review of operations. None of the

CHFP treatments have reduced neonatal mortality, although health technologies that are being investigated independent of the CHFP may have had beneficial effects. In Cell 1, there is no apparent under-5 survival effect of the project. In fact, in the second year of life, mortality risks may even increase slightly. Hypotheses, which explain this effect, are under investigation. However, the CHFP has reduced childhood mortality. This impact of the CHFP is likely to operate through improved treatment of acute respiratory infections, malaria, and diarrhoea, or possibly improved childhood vaccination coverage. The precise causes of the survival impact of the CHFP remain the subject of investigation and observation. However, preliminary evidence suggests that childhood mortality may be substantially reduced by CHO community-based health care.

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LIGHT AT THE BEGINNING OF THE TUNNEL

Lessons learned from the Navrongo project have important programme implications. Phase 1 of the experiment aimed to determine the most effective way (in terms of cost, coverage, cultural compatibility, and quality) of delivering health care services to rural people. Phase 2 tested the strategies in a district-wide trial. As findings emerge, important lessons are learned:

Lesson 1: Need for community-based services

In remote and very rural and traditional communities, mobility of women and autonomy to seek health services is extremely limited. To succeed in providing access to quality health care to all, services must be based in the community. This has been achieved by fostering volunteer construction of Community Health Compounds (CHC) where nurses, termed Community Health Officers (CHO) live and provide services.



There is the need to train more frontline staff such as these student nurses

Lesson 2: Community health officer (CHO):

The trusted outsider

When CHC are placed too close to the Chiefs' compounds or when nurses are related to influential families, performance is less than if nurses are outsiders. This is particularly true of FP services. Women prefer female service providers who have no links to the community and can be trusted to keep secrets about FP supplies.

Lesson 3: *Yezuru Zenna*: The trusted insider

When men are recruited as health aides, termed YZ they are viewed as community health mobilisers who contact men to discuss and legitimize the programme. These are appropriately socially gregarious individuals who are from the communities they serve.

Lesson 4: The need for more nurses

When services are restructured to reach people and staff of the MOH are redeployed more efficiently, old staffing norms become obsolete, meaningless, and constraining. A nurse living in the community is at the beck and call of people around the clock. She has no opening hours and no closing hours. She does everything from health education, curative services, counseling, midwifery, and community mobilisation. These services constitute a very large increase in her workload as compared to a nurse

that lives in a health centre. A sub-district clinic nurse is instructed to start her day at 8:00am, but she rarely arrives at work before 10:00am. Her work schedule hardly occupies her full time, so she typically closes around 12:00 noon by which time the number of patients has considerably decreased.

A nurse living in the community feels lonely most of the time. She complains of being on duty 24 hours without a day without anyone to relieve her. Staffing norms must be readjusted to take care of redesigned service delivery strategies that create demand and improve service utilization. The number of CHO currently assigned to KND is too small for achieving adequate coverage of the communities with the expected quality of service. Consideration should be given to increasing the density of CHO so that they can establish contact with all compounds in their area on regular basis. The fluctuations observed in compound visitation coverage reflect demands on the nurses' time as they are withdrawn from the communities to respond to other demands such as epidemics, sickness, and or mop-up activities that of necessity take them away from the communities without finding other nurses to provide relieving duties in their absence.

Lesson 5: Addressing men's concerns

An interesting finding of the experiment is the willingness of men to discuss FP with the CHO, who are women. Women can serve quite effectively as information providers to men, so long as strict secrecy about the contraceptive decisions of wives is maintained at all times. Using a male approach that involves meetings with elderly men also helps tremendously to defuse opposition, which is mostly based on fear of the unknown. Men make the decisions in the community, but know very little about FP. Their opposition to FP is therefore based on ignorance. A positive male approach to FP yields better results in the increased use of FP. By constituting village elders as Health Committee Members and involving them in discussions on FP at public gatherings, legitimacy and the notion of some level of acquiescence is given to FP and this greatly improves the atmosphere for individual FP decisions.

Lesson 6: A sustainable construction initiative

Communities construct CHC for the CHO to use as their residence and “Level A” clinic. This is a low-cost programme that can be implemented anywhere. However, over-reliance on traditional architecture and building materials can lead to unsustainable structures. Traditional compounds are built by men through communal labor, but routine maintenance is carried out by women. CHO are too busy to perform maintenance work on their compounds; roof leaks often develop, causing structural problems. A typical traditionally designed structure as residence for the community-resident nurse is not sustainable. Modest resources from the MOH (or through the District Assembly Common Fund) and other sources should be committed to providing building materials for the CHC and latrines, in addition to providing some funds for mobilising community labour to put up the structures.

Lesson 7: System support

Village work is a new challenge for the CHO because it's a system that requires mechanisms for technical, community and supervisory support for their work. Frequent practical training sessions are needed to develop community liaison and teamwork. A new MIS system has been developed to foster “bottom-up” communication. Workers meet frequently, assemble

narrative reports, discuss progress and problems, and communicate matters of concern to senior officers.

Lesson 8: Community participation

Mechanisms for traditional governance and group action can be utilized for communicating with communities. Liaison with chiefs, elders, and lineage heads, cooperation with village peer networks and group leaders can legitimize and explain FP to men. Durbars are particularly useful for health education and FP. Chiefs, elders and community leaders welcome dialogue with the MOH staff and seek regular exchanges. A regular programme of community dialogue and exchange should be part of every DHMT work programme.

Lesson 9: Focus on primary health care

Since mortality is high and health concerns are limited, critically needed preventive health care should be taken to every compound. Health education must be compound relevant and compound specific to be meaningful to community members. This allows them to practice what is contained in the health education messages directly and observation of the benefits reinforces compliance to advice provided thereafter. Community members subsequently build trust in the health worker and the health service delivery system that they see as responsive to their needs. Under such conditions of mutual trust, acceptance of FP makes sense and opposition to it becomes minimal, even among men.

Lesson 10: The CHFP works

When nurses are deployed to village locations, significant improvements in child health are realized. When *Zurugelu* activities are added to the nurse in the village condition, so that CHO services are complemented with activities for mobilising chieftaincy support, health committees, volunteers, and community durbars participation, then contraceptive use increases and fertility declines.



Working together works: Project staff collaborating with district health management team

Volume 1, Number 12, 2001

FAMILY PLANNING: GOOD FOR SOME; A WORRY FOR OTHERS¹

Since the inception of *The Navrongo Experiment* in Ghana in 1994, the prevalence of contraceptive use has increased in areas of the district where nurses live and work in villages and where *Zurugelu* activities are also launched. The success of this strategy demonstrates that appropriately formulated FP programmes can succeed, even in a rural and traditional social environment. But, the status of women in this setting is constrained by customs that define their roles at the time of marriage. Owing to the custom of bridewealth, many men view wives in the manner of property, extended families involved in marriage arrangements assign great value to childbearing. In this context of social support for childbearing and constrained women's autonomy, community-based FP program can generate tensions between men and women. The CHFP launched an investigation of the potential for tensions and developed program interventions to prevent them from arising.

What sustains women's interest in contraceptives?

Survey results suggested that women were more willing than men to discuss FP, which may indicate stronger female interest. Contraceptives allow women to reconcile a tension with which they are faced. To sustain their health, women must space childbearing. Traditional beliefs ensure that this will happen. For example, women report that semen and mother's milk are incompatible. Nonetheless, women are expected to fulfill their husbands' desires. Caught between sexual obligation to husbands and personal need to care for children and the need to space childbearing, FP provides a woman with means to reconcile these seemingly incompatible goals.

Even when you tell your husband that you would not like to have another child (yet), he will tell you that he paid the bridewealth, so that he can have children with you and that you have no right to tell him not to have sex with you. He may get physical. In order to avoid any confrontation, you will go and use a method, so that he can have sex with you while you plan your family.

Old woman, Naga

If my husband marries a second woman and he does not want us to do [family planning] and *she* doesn't do it, he will love her; he will not love me again. If he has something small, he will give it to her and leave me...In the night I will be sleeping alone with all my family planning...

Young woman, Naga

Women's fears

In spite of, and in part because of, its uses, FP has strained gender relations, with significant repercussions for women:

- *Domestic violence.* Women often adopt FP in secret. And yet, more women than men felt that wife beating was a justified response if a husband discovers this.
- *Losing favor.* Women expressed concern that men would lose affection for their wives or even favor other wives if they disapproved of contraceptive use—an especially potent threat in this polygynous society. Indeed, contraceptive use without spousal approval may be grounds for divorce.
- *Monetary cost.* Within this context of extreme poverty, even minimal fees incurred for FP can represent a significant burden. As men control primary household funds, their disapproval further limits women's access to FP.

Some women...may not feel free to do so [practise family planning] because there is a belief among many women that the ancestors are against such practices, and that one may die or may not get any blessings from the ancestors if she practices those things.

Young woman, Paga

¹Draws on Bawah, Ayaga et al. 1999. "Women's fears and men's anxieties: The impact of family planning on gender relations in northern Ghana," *Studies in Family Planning* 30(1).

The contraceptives really help, and we are not against the use of these methods, but if a woman comes to the clinic without the husband, [you should] insist that she bring her husband.

Young man, Naga

- *Disapproval of extended family.* Though members of the extended household are less influential than in the past, conflicting views about contraceptives extend beyond the immediate family.
- *The sanctions of traditional religion.* Some women state that they fear that FP will provoke the ill will among ancestors.

What's at stake for men?

In a patriarchal society, gender stratification is deep-seated; a conduit for independent female action is consequently threatening:

- *Women's obligations.* Bearing children is part of a woman's wifely duties to her husband and to his lineage, as required by the payment of bridewealth. In discussions, men emphasized the security of having many children, a security threatened by enabling a woman to limit childbearing.
- *The question of fidelity.* A woman's use of FP may allow for or encourage infidelity to her husband, which embodies an affront to the image of the husband and the household. Further, contraceptive use is tantamount to abandonment of the tenets of, or a lack of investment in, the marriage.
- *Who's in charge?* Insofar as the Navrongo programme vests women with the possibility of asserting their reproductive preferences, it engenders anxiety among men. Women who make independent FP decisions run the risk of harming the name of the household if problems arise; men, meanwhile, are precluded from a clear assertion of their reproductive choices.

Ways to cope and programmatic responses

Given this environment of gender stratification and imbalanced authority and autonomy, the possibility that

women may regulate their fertility is undoubtedly menacing. The Navrongo project has devised three areas of programmatic response:

- *Supporting women.* Kassem and Nankam women have, in their own right, protected themselves amidst social tensions. Focus groups discussed women's attempts to explain uses of contraception to their husbands, women earning their own income (for instance, by gathering firewood), wives publicly shaming husbands who did not support their choices, and women clandestinely using FP. In addition, the Navrongo project has assembled teams of male supervisors who attend to FP-related conflicts by visiting identified households and drawing community attention to the husband in question. Furthermore, the involvement of community leaders has effected more subtle changes in relations between the genders.
- *Involving men.* Through specially organized sessions, through meetings of male village associations, or through the personal involvement of fieldworkers, the project's FP and health messages were addressed to men, and as the programme has become increasingly known, these efforts have begun to



Family planning enables women to assert their reproductive choices

converge with outreach to women. Community visits by programme volunteers are intended to legitimize contraceptive use.

- *Mobilising community support systems.* By involving the cooperation of chiefs, elders, and lineage heads, the Navrongo project made use of *durbars*—community meetings convened to discuss specific issues—to present its health research programmes. Paramount Chiefs voiced their support for FP during these discussions, which have, since the Navrongo project's involvement, been held more frequently, and focused more on health and contraceptive themes.

Further, the traditional *durbar* custom has been expanded to include women in an effort to foster more open exchanges about FP.

Conclusion

Developing FP services on the Navrongo model requires strategies for putting men at ease, involving male leaders, and supporting women in their desire to implement reproductive preferences. The CHFP demonstrates simple-to-replicate means of mobilising cultural resources for supporting couples who adopt FP.

Volume 2, Number 1, 2002

WHERE DID THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES INITIATIVE (CHPS) COME FROM?

Over a third of all districts in Ghana have activities underway aimed at converting static-based services to community-based health and FP care. This national programme is known as the Community-based Health Planning and Services Initiative, or CHPS for short. Various Directorates of the GHS are involved in implementing this programme; Regional Health Administrations are also involved. Donors are contributing in various ways; private voluntary agencies such as EngenderHealth, JPHEIGO, the Johns Hopkins

When Navrongo presented preliminary findings of the CHFP, a national policy statement emerged declaring that community-based health care, built on the Navrongo model, was a priority programme of the Ministry of Health. Since then CHPS has had a history of its own.

Communications Centre, the Population Council, and PRIME II, all have activities designed to contribute to the CHPS programme. Where did CHPS come from?

Step 1: Getting it right: The three-village pilot

Ever since 1994, the Navrongo Health Research Center (NHRC) has been engaged in research on community-based service delivery in the KND in the Upper East region of the country. A pilot programme of strategic planning was conducted to develop the service model.

Step 2: Testing it out: *The Navrongo Experiment*

The pilot was scaled up to a district-wide experiment. Results were disseminated demonstrating the feasibility and usefulness of reorienting health care at the periphery. The experiences and lessons of the experiment reinforced the Ministry's commitment towards community-based health service delivery through the replication and adaptation of this approach in other parts of the country.

Step 3: Telling the story: Dissemination and diffusion

Initially, deliberations on the potential use of Navrongo focused on the possibility of extending operations to the



Where it all began



Trainee nurses looking forward to the new health service delivery initiative

three northern regions (Northern, Upper East, and Upper West) where the health indicators, cultural institutions, and ecological zone were similar to Navrongo. However, this option was redirected by the Ministry in favour of an approach that would foster the diffusion of operational change throughout Ghana. All regions of the country were to have a district where Navrongo operations would be adapted to local conditions, scaled up, and used to inform the process of change. Several consultations were held with the Deputy Minister of Health, the Director of Medical Services, the Director of Human Resources Division, the Health Research Unit, and the NHRC. All key policymakers were in favour of replication and expansion of the Navrongo experience but all acknowledged the need to build a sense of ownership of the change process by the Ministry. It was decided that Navrongo would focus on its mandate (conducting research on a broad range of health and policy issues in KND) and would not administer the scaling-up programme. However, Navrongo would continue to play a key role in disseminating lessons from its research by orienting visiting teams to the Navrongo experiment. Any district that showed committed and enthusiastic leadership was to be assisted in initiating scaling-up activities after certain key structures were put in place. Almost immediately, in the dissemination period, several districts

(Bawku West and Bolgatanga districts in the Upper East region; Nkwanta, Ketu South, and Sogakope districts in the Volta region) visited the NHRC and used the experience to plan replication of the Navrongo approach to community-based service delivery in their respective districts. This spontaneous replication soon demonstrated the feasibility of adapting and using the Navrongo community health system in other areas of the country.

The first consultative conference involving directors of the various divisions of the Ministry, and funded by the Rockefeller Foundation, was convened by the Director of Medical Services and coordinated by the NHRC at Ada Foah from September 3–5, 1998, to discuss the Navrongo community-health strategy and the way forward. Policymakers, directors, division representatives, and programme heads of the Ministry attended the meeting. The meeting developed a common vision and defined the roles of the various units of the Ministry in reorienting health care delivery at the periphery and encouraged contributions from the directors. Nkwanta District played an instrumental role by discussing experience with replicating Navrongo, thereby demonstrating that utilization of the experiment, with local resources, was feasible in other districts of the country. Critical discussions were held on human



The Community-based Health Planning and Services Initiative (CHPS) has come a long way—there's a lot to smile about

resources as well as financial, monitoring and evaluation, and capacity-building implications of the initiative.

Step 4: Scaling up

A National Dissemination Forum was convened at the La Palm Royal Beach Hotel, in Accra in October 1999. This meeting established wider dissemination of the lessons and experiences of the *Navrongo Experiment* to all health service provider stakeholders nationwide. Implementing this programme would involve the various directorates and the Regional Health Management Teams, but the effort to coordinate the programme would be known as “CHPS.” From that point on, CHPS has had a history of its own.

Volume 3, Number 2, 2003

FERTILE GROUNDS FOR FAMILY PLANNING

Fertility levels in Sahelian West Africa are double those observed in other developing countries. Many respected observers have emphasised the resilience of pronatalist social institutions in this region by noting that African religious customs, lineage and descent systems, kinship networks and family structure reinforce high fertility social norms, beliefs and values. The position supports the view that high fertility is a reflection of the desire for children, and that improving access to FP services will have little or no effect on fertility. Other analysts who have assessed the implications of successful pilot FP programmes have concluded that existing demand for services is sufficient to bring about a reduction in fertility.

Despite a climate of uncertainty about what works in such settings, most reproductive health programmes in sub-Saharan Africa focus on improving access to FP services. In the 1980s public investments in FP focused on constructing sub-District clinics and posting large numbers of Community Health Nurses to them—resulting in far more nurses sitting in clinics than were needed to care for walk-in patients. This had the

unintended effect of isolating public investments in health care from communities that the programmes are meant to serve. Even if programmes can be shown to bring about increases in contraceptive use, whether this increased use translates into fertility decline is yet to be demonstrated. Attention was also directed to deploying volunteers as “Community-based Distribution” (CBD) agents, without systematic investigation into how CBD should be organized and whether it actually works.

The CHFP set out to measure the relative impact of different types of health delivery strategies in a rural community. The experiment had a research design to provide a basis for understanding the process of reproductive change. Baseline characteristics of the population of women of reproductive age and their husbands were documented. Follow-up panel surveys and a longitudinal demographic surveillance system monitored changes in contraceptive knowledge, reproductive preferences, reproductive behaviour, and fertility. Four cells represented different health service delivery strategies. The MOH approach focused on fixed-facility health care delivery under which essential resources are lacking, community mobilization and supervising systems are weak, and community accountability is rarely developed.

Under the Nurse outreach arm, a CHO is deployed to live among the people and provide doorstep and compound-specific health care. This approach bridges



Can family planning bear fruit among people who put a premium on large family size?



A good harvest doesn't depend on the number of crops grown and labour invested—the crucial issue is how the crops are spaced

social distance between service provider and client, thus making the service delivery atmosphere friendlier. The *zurugelu* arm directed attention at using community-level cultural resources to organise health care delivery. This approach involves constituting health care action committees from existing social networks, and implementing supervisory services with active traditional village self-help schemes. The services are provided through the use of community health volunteers who are chosen by the community and trained by project staff to provide basic health care services, reproductive health education, outreach to men, and contraceptive supplies. Outreach to men is undertaken by community gatherings known as *durbars* at which discussions focus on health and FP themes to give men an open forum to discuss their reactions to the programme. The gender strategies and communication activities of the *zurugelu* arm of the experiment were expected to alter the social context of reproductive change by legitimizing the concept of FP among men, by opening community dialogue about health and reproductive matters that traditionally were not discussed between spouses, and by involving women in social leadership that previously had been the preserve of men. The third arm of the experiment combines the MOH nurse outreach services and the

zurugelu approaches. The hypothesis to be tested here was that the social costs of contraception can be reduced through community mobilization

The context

The KND is located in the most impoverished region of Ghana. The study area is therefore remote and isolated although with limited exposure to outside influences and ideas arising mainly from trade and migration to southern Ghana. The hostile ecology and dispersed settlement pattern accentuate social isolation and complicate efforts to organise health and human services in the locality. Most of the populations are Kasem and Nankam speakers. These are ethnic groups with historic migratory links with Sahelian people to the north of Ghana. Local languages thus provide only fragmentary communication links to Ghana's southern cultures and restrict exposure of the population to outside ideas generally.

The adoption of modern FP methods is constrained by various cultural traditions that restrict women's autonomy and shape men's perceptions of the value of children. Baseline data show that 42 percent of all currently married women were in polygamous unions in 1993. Baseline literacy of currently married women is only 7 percent further isolating women from the outside world. Taken together, the institution of marriage and the extended family system impede the introduction of new ideas about contraceptive technology. Focus group discussions suggest that women's decision to adopt contraception is often at odds with perceptions of appropriate female roles and the decision may cause contraceptive adopters considerable risk of embarrassment and ostracism from their husbands, co-wives, and kin. Despite these constraints on contraceptive use, knowledge of methods was widespread in the baseline period. The ability to spontaneously name a modern contraceptive method ranged between 32 and 52 percent of respondents in the various treatment cells in 1993. Although most women knew of a method when prompted and could identify a supply source for a modern method when asked, baseline prevalence of contraceptive use was low



Women have expressed their fertility preference for spacing childbirth but we are still far from the end of the road

in all treatment areas especially in the comparison area of the experiment.

Despite social constraints to contraceptive use, more than one third of respondents in the 1993 baseline survey expressed fertility preferences for spacing additional births. Although traditional reproductive control mechanisms such as prolonged postpartum abstinence are widespread and may reduce fertility substantially, child spacing preferences stated in surveys are consistent with FP. This suggests that desire for fertility control exists that could be addressed with services. Is the issue of “unmet need” an artifact of biases that are associated with the survey interview paradigm in this setting? Can demand stated in survey data be met with services? These issues have been thoroughly investigated and sizzling results are now being made available. Interested in finding out the outcome of investigations? Grab the upcoming note titled, *“Women Speak, Men Listen.”*

Volume 3, Number 10, 2003

DO YOU SPEAK MATHEMATICS?

What is the sum of “One strategy, two goals, six milestones, 15 steps, and 20 activities”?

For nearly a decade, the NHRC has conducted field research, demonstration, and training directed at developing, testing, and disseminating systems for community-based health care. Initially launched as a three-village pilot in 1994, and phased in as a field experiment in 1996, the CHFP began to demonstrate evidence of success by 1998. Informal exchanges between project investigators and visiting District Health Management Teams (DHMT) generated a series of replication projects in other districts. Beginning in 1999, CHPS was derived from the need to organize a national programme, based on the experience of a few DHMT that had visited Navrongo and adapted CHFP services to local needs and conditions. Since the creation of CHPS, enthusiasm for community-based care has grown, as indicated by reports from the GHS Policy Planning Monitoring and Evaluation (PPME) Division showing that nearly all DHMT intend to launch the programme. However, PPME monitoring has also shown that this enthusiasm to plan CHPS implementation has not translated into successful action in many districts. Moreover, individuals responsible for coordinating implementation are often unclear about the CHPS agenda and ways to get work started. Thus, without guidance from coordinators, and without experience with actual service delivery, there is mounting confusion about how to proceed, with many districts unable to proceed beyond the planning stage. This problem can be addressed with an experience-based counterpart-training programme for CHPS implementation teams—coordinators, DHMT members and potential Community Health Officers (CHO). Training will provide district participants with hands-on experience with CHFP operations, implementation strategies, and pilot planning. Trainees will complete the essential tasks of zoning districts, launching community entry, and establishing pilot services. Experience gained will provide CHPS with a team of knowledgeable coordinators and frontline staff with a clear sense of their mission in the programme.

The CHPS Initiative. The CHPS Initiative has established a website at www.ghana-chps.org that explains the national strategy for the programme and

presents monitoring results. DHMT are encouraged to launch the programme in steps and phase in operations in work areas termed “zones” where components of the programme are implemented over time. In each zone where CHPS is implemented, there are 20 implementation activities embedded in 15 steps. Steps, in turn, produce six essential milestones in implementation: planning for the process, “community entry” (orienting chiefs and leaders), constructing or renovating “community health compounds” (CHC) where nurses live, posting trained nurses to CHC, acquiring essential equipment, and launching volunteer services. Where CHPS functions well, districts have been mapped and zoned into catchment areas where the six milestones are phased in over time, according to staff capacity, resource availability, and community readiness to launch the programme.

The problem

Though countrywide enthusiasm for CHPS has accelerated, this enthusiasm has been offset by serious obstacles. Monitoring results of the PPME Division show that most districts that have stated in reports that they intend to launch the initiative remain at the “planning” stage, unable to cross over to other milestones and move forward. Only about 10 districts have so far been able to deploy a CHO to a community to provide service. Zones where CHPS is in full-scale operation comprise less than five per cent of the population of

Ghana. Carefully conducted PPME qualitative appraisal of the programme has clarified some of the reasons for this “implementation gap.” It is attributed to a variety of reasons including, but not limited to, fear of community health nurses being deployed in village locations and then forgotten; suspicion among other health staff afraid that the CHO would diminish their role and importance; community members feeling they are being shortchanged by being sent “low cost” health services when they have asked for a hospital or clinic; and inability of the DHMT to engage the various stakeholders in dialogue to get things off the ground. District leaders and supervisors share a certain fear of the unknown, particularly in regard to financial commitments, and the prevalent view that external resources are required to get CHPS started.

The solution

Without a firm grasp of the concept of CHPS, fears in getting started, to a very large extent, are justified. Regional and District CHPS Coordinators have been appointed in all the regions and districts to address these problems and coordinate CHPS activities; yet they are not well oriented regarding CHPS and are thus poorly positioned to bridge the “implementation gap.” There is the need for practical demonstration of the program that puts participants at ease with the CHPS initiative and develops consensus for CHPS implementation. Since 1997, Navrongo has hosted DHMT with this objective. Now there is a need to extend this approach to include the newly constituted cadre of CHPS Coordinators also so that they have a firm grounding in the steps and concepts underlying the programme that they are coordinating. This is based on the observation that districts where remarkable progress has been recorded are all led by DHMT members who have visited Navrongo, Nkwanta, or other districts where the program is operating and received practical training in how to launch the programme. Under counterpart systems training—designed to demonstrate all aspects of the CHFP service regimen—all health staff can receive practical orientation. In this approach, the system is demonstrated by expert participants to counterparts who



CHPS: Taking one step at a time

observe operations and adapt lessons to their own local circumstances and needs. When Navrongo orientation has worked well, it has led to pilot implementation of the CHPS programme in one or two zones where learning-by-doing takes place, followed by counterpart demonstration in the implementing district. The Navrongo approach is therefore more a matter of starting a catalytic process than a program for technical training. This involves:

- *Orienting counterparts to key concepts.* The notions of steps, zones, community mapping, community participation, and so on, is demonstrated with the aim of providing direct experience with implementation of CHPS activities, problems encountered, and solutions reached in the Navrongo setting.
- *Demonstrating ways to coordinate CHPS with existing GHS priority programmes.* CHPS is not a vertical programme. It is a strategy for improving the implementation of EPI, school health, FP, reproductive health, and curative health services. Navrongo counterpart training provides practical experience for coordinating the implementation of CHPS in conjunction with GHS priority programmes.
- *Coordinating monitoring and evaluation (M&E) activities.* Interacting with counterparts builds practical understanding of the M&E checklist items, ways to orient DHMT in M&E procedures, and strategies for checking on the quality of M&E reports.
- *Learning-by-doing.* Frontline staff, i.e., CHO, serve as on-the-job trainers for counterpart CHO who are assigned to CHC and learn-by-doing. Visiting CHO gain experience on service delivery in Ghana's most deprived and poorest region, which demystifies village posting.
- *Grasping supervisory techniques.* CHPS supervisors are not always clear about what to look for during supervisory missions to the field. In the counterpart approach, trainee supervisors are attached to role-

model supervisors who serve as a guide for field activities. District Directors of Health Services and District Nurse Supervisors work with senior CHFP staff. Navrongo counterpart training orients supervisors toward not finding fault and assigning blame, but toward understanding how the system works and how to solve practical problems.

- *Utilizing communities as classrooms.* At every stage of counterpart training the communities serve as classrooms for training health professionals in ways to make the CHFP replicable in other parts of Ghana, and indeed in other parts of the developing world where strategies for organising a community-based health care delivery system that works are still being researched. Once DHMT experience this resource, they can develop pilot communities where CHPS works and where communities may lead other communities in health service innovation.

Navrongo demonstrates that districts leading CHPS progress should be providing counterpart support to other districts. Spreading the CHPS message is best achieved by those who know from practical experience what it takes to get started and make the programme work. Where CHPS is working, participants are not talking about the mathematics of steps, milestones, and components. They are simply getting things done.

Volume 3, Number 18, 2003

CHILD SURVIVAL: WHAT WORKED AND WHAT FAILED?

The goal of "Health for All by the Year 2000" has not been achieved in rural Africa. At the end of the millennium, infant mortality remained above 100 deaths per thousand live births in the sub-Saharan region (United Nations 1998). Fully two-thirds of all deaths among children under 5 years, and half of the years of life lost in the region, are attributable to measles, malaria, diarrhoeal diseases, and acute respiratory infections, often acting in synergy with malnutrition.



Volunteers with drugs: The wrong road to take

Low-cost and effective preventive measures and treatments for averting the major direct causes of child morbidity and mortality have been available for more than three decades, yet the implementation of effective programmes for delivering these technologies remains an elusive goal. International interest in establishing health for all has led to regional health agendas, such as the UNICEF-sponsored “Bamako Initiative,” which promotes the idea that managing health care resources and providing revolving funds for primary health care drugs and services through community volunteers can be a sustainable means of achieving Health for All. Other approaches have emphasized the need for placing paid paramedics in communities.

To this day, debate persists about the relative effectiveness of volunteer versus paramedic-provided care. Paramedics are widely viewed as an effective approach to reducing mortality, but the feasibility and sustainability of posting paramedics to communities is often questioned, with the volunteer approach advocated as a low-cost and sustainable alternative. The CHFP project responded to this debate by testing the relative effectiveness of these strategies for achieving Health for All. In keeping with the spirit of Health for All, facilities, staff, and medical supplies utilised in the experiment are resources routinely available throughout the region and all study areas of the district have the same density of health care providers per population, the same level of training, and the same medical supplies. The experiment

tests the effectiveness of alternative strategies for utilising these resources at the community level.

The zurugelu intervention involves mobilizing traditional social institutions in health delivery and planning, as called for by the “Bamako Initiative.” Village health committees, termed YN, were established in collaboration with chiefs, elders, and other community opinion leaders. The YN oversees a cadre of volunteers called YZ, or health volunteers, who form the backbone of the zurugelu approach. The main purpose of the YZ is to sell the CHFP idea to community members, particularly men who exert considerable influence over decisions about women’s mobility to seek health care. YZ receive two weeks of initial training and quarterly refresher training. They visit households to talk about hygiene, child immunization, and other health issues, and to make it known that they are available for basic treatment and referrals. They have significant health resources at their disposal, including Paracetamol for febrile illnesses, chloroquine for malaria, Aludrox for abdominal pains, and multivitamins, but they do not have antibiotics or vaccines. Instead, they provide referrals to the clinics and help organize immunization campaigns. Another important element of the zurugelu intervention is the *durbar*, or community gathering, which is traditionally used by chiefs to mobilize community action on some issue of common concern. Durbars provide an effective means of communicating project messages to communities, establish the credibility of the project, and build community support for project activities.

A health service mobilisation intervention tests the effectiveness of improving access to 16 Community Health Officers (CHO) by reassigning them from sub-district clinics to community-constructed residences, known as Community Health Compounds (CHC) and equipping them to conduct door-to-door health services. CHO are trained for two years, paid a monthly salary, and provide a wider range of health intervention options than YZ.

In the combined intervention area, the zurugelu and CHO approaches are pursued simultaneously. This intervention tests the hypothesis that the zurugelu and

MOH mobilization interventions are complementary and synergistic, combining the implicit accountability and sustainability of the former with the relative advantages of professionalism in the latter. In the combined treatment area, close collaborative links have been established between the YZ and the CHO.

Results have been analysed separately for ages ranging from infancy (0–11 months) to early childhood (12–23 months), to late childhood (24–59 months) adjusting for possible differences in risk by sex of the child; mother's age, education, and residence in the compound; the number of residents in the compound; and distance from the compound to the nearest health facility and to Navrongo Town. Findings are, as follows:

- Infants exposed to CHO services have 12 percent lower mortality than those not exposed, although this effect largely disappears when statistical procedures adjust for maternal and child characteristics. The impact of the CHFP on infant mortality is evident, but not pronounced.
- Exposure to the zurugelu/"Bamako" strategy is associated with an *increase* in the odds of early childhood mortality by nearly two-fold.
- In late childhood (24–59 months), exposure to two years or more of the CHO service activity is associated with nearly a 60 percent *decrease* in mortality among children exposed for two years or

more to project interventions. Throughout childhood, the child survival difference between communities exposed to zurugelu and CHO-only approaches is huge; CHO far outweigh the effect of the volunteer.

- The combined cell of the experiment has no apparent effect on late childhood mortality, possibly because CHO effects are offset by the detrimental YZ effect.

The impact of placing a CHO in a community, without zurugelu activities, is greater than expected. This finding strongly supports the CHPS policy of building CHC, posting CHO to communities, and mobilizing communities to support their service delivery work. The CHFP results clearly show that doorstep and community CHO services represent an important step toward achieving Health for All.

The zurugelu result is unexpected and calls for further investigation and action. One possible explanation for the increased mortality is that mothers in the zurugelu cell may be using the more accessible and less expensive but less well-trained services of the YZ in situations where they might otherwise take their children to the sub-district clinic or to the CHO. Careful investigation of this hypothesis has demonstrated, however, that YZ are trained to refer, and are not treating febrile children. Only a small proportion of all health care in YZ work areas is actually provided by volunteers. Therefore, volunteers are not introducing health risks. But, it is also apparent that YZ lack the credibility that parents seek in pursuing health care options. Nurses in the community substitute for traditional healers, accelerating the introduction of effective health technology when it is needed. But YZ do not affect the traditional pattern of health-seeking behaviour, so that a sick child experiences delays that arise from parental consultation with healers. Results show that this pattern of interaction fails to address the needs of children; whereas nurse provided care has major health benefits. Findings therefore attest to the need for caution with introducing the CHPS volunteer strategy. Utilizing volunteers as health mobilisers is more appropriate than utilizing them as health service providers.



Health volunteers' crucial role as social mobilisers should be tapped for the Community-based Health Planning and Services Initiative

Volume 4, Numbers 1, 3, 4, 14, 2004

EVEN THE BLIND CAN SEE: KATIU CHIEF

Would you say the NHRC has had any impact on health in your paramountcy? Could you explain by giving examples?

The activities of the NHRC have had a tremendous effect on the health of people in my traditional area. The CHO has been particularly helpful. She has rescued us from the cruel hands of diseases like Cerebro-Spinal Meningitis that had been striking us— especially children. Before her coming, headaches and abdominal diseases were rampant. Now fever and malaria seem to be our main problems, but she is working seriously toward bringing these diseases under control.

Did anyone from the NHRC come to see you about the CHFP? Can you describe the first such occasion when someone from the NHRC came to talk to you about the CHFP?

I was not the chief at that time I was a member of the Council of Elders in the chief's court. I remember the NHRC came and said it was coming to listen to our health problems and together find practical solutions to

them. They said they would send a nurse to live with us so that when our children fall sick she is there to help them.

Having expressed the reason for stepping into your community, what was your immediate reaction?

We readily accepted the nurse into our midst hoping we would benefit from her work. We have not been disappointed at all. She has been very helpful in attending to our women especially during labour. There have been safe deliveries over the years though occasionally some children or their mothers die during childbirth.

We have many nurses in other communities and some complain that most mothers refuse to bring their children for health care services. They also complain that people do not often turn up to provide labour when it comes to maintaining Community Health Compounds (CHC) for example. Do you experience such occurrences here?

There are no such problems in my locality at all. People readily go to her for medicine when they fall sick. Women also attend antenatal health care clinics and patronize other health services.

We know you are visually impaired. Can you really see that healthwise things have changed in this community?

Of course I can. He is blind indeed who cannot even see that the health of the people in this community has improved dramatically over the years, thanks to the resident nurse. As an elder I attend fewer and fewer funerals and hear of fewer and fewer pregnancy-related deaths. I am not saying these things don't occur anymore. I am saying they are few and far between. I don't hear of measles any more.

Are there any aspects of health that you think have not been addressed under the CHFP? What do you think should be added to the programme?

I think the nurse is doing very well. In fact she has been attending to all our health problems and I don't think



He is blind indeed who cannot even see that the health of the people in this community has improved dramatically over the years....” says the Katu Chief



Nurse and client meet under the baobab tree for the latter to take her injections

there is something left out. However, when there are new developments, we shall let her know for immediate attention.

From the various types of services that the nurse provides, which of them has touched your heart?

I will say the services she renders to pregnant women especially during labour. She attends to them with expertise and they deliver safely. This aspect of her work touches my heart most.

The sub-District Health Centre in Asunia is mandated to cater for all the health needs of the whole West zone. Why do you still need a nurse in Katiu?

We are also concerned with our own locality and her deployment here makes it easier for us to get medical attention without having to travel to a different place.

There has been an unpleasant incident here with the nurse relating to theft. How did that happen?

We have had the misfortune of someone breaking into the nurse's residence and making away with her belongings. That was very unfortunate but we took swift action as soon as it happened. I sent a search squad which travelled 900km to apprehend the culprit, had him tried, and thrown into jail. That decisive action is a strong warning to others that undisciplined acts will not

be tolerated—especially with regard to the nurse. The community has a responsibility to protect and defend the nurse and we shall not fail to do our duty.

A study has indicated that the ancestors are not averse to FP. As a traditional ruler, do you agree with this conclusion?

In those days, our ancestors consulted gods when their wives were about to deliver. What I also remember about them is that they never planned their families. They gave birth until the woman reached her menopause. Now the ancestors see us from wherever they are and I am sure they know things have changed. If things had been so in their time I believe they would have embraced FP the way we have accepted it today.

The work of the nurse has been acclaimed as the most effective way to deliver health services to rural people. Now the government has asked districts throughout the country to replicate our example. How do you feel about this?

I am happy to hear that our good work is going to be replicated in other parts of Ghana and in lands far and near. It is something to smile about. We really helped the nurse as she helped us and her work has been running smoothly.

DYING FOR HEALTH: NAGA CHIEF

Would you say the NHRC has had any impact on health in your paramountcy? Could you explain by giving examples?

In fact the work of NHRC has come to save us from a lot of illnesses. One, children used to die a lot from measles. Since the coming of NHRC, that has reduced a lot. Two, women used to die here during delivery. These days, we don't see anything like that. So NHRC has helped us a lot.

Did anyone from the NHRC come to talk to you about the CHFP? Can you describe the first such occasion when someone from the NHRC came to talk to you about the CHFP?

The NHRC came and told my elders and I that they were bringing a nurse here so we should provide a building for her. Everybody was happy so they came out in numbers and built the nurse's quarters.

A study has indicated that the ancestors are not averse to FP. As a traditional ruler, do you agree with this conclusion? Why do you agree or disagree with this conclusion?

What the ancestors said is true. FP is good and we accept it. Why we hesitated in embracing the concept was the fact that our children were dying of measles. But when the NHRC came and this stopped, we took FP. We need to plan our families because if you have children and you cannot feed them, school them or send them to hospital when they are sick, then it is better they were not born.

Some workers report that there is community apathy about the CHFP. Do you agree with this assertion? What have you done to address such issues?

Yes, it happens here in Naga. The issue is that some do not still understand the work of the nurse. So we have people here like that. We have tried in our own way to address this but we have also reported this attitude to the NHRC and we tell them issues related to that. Apart from that, I have been talking to my people during meetings that they should try and stop that. We have



With a nurse in their midst, Naga people no longer have to die for health

realized that sometimes women sneak to the nurse and have their FP. When the husband hears about it there is a problem with the nurse. Perhaps the men are apathetic about the CHFP because of the fear that the nurse's residence will only be used to provide FP for their wives without their consent. Sometimes the men feel the nurse is probably there to do FP for the women so why should they take part in constructing quarters where their wives would sneak and go for FP? But attitudes are changing as men get to know more about FP and understand better the nature of the nurse's work.

Are there any aspects of health that you think have not been addressed under the CHFP? What do you think should be added to the programme?

None that I can immediately think of.

Have Health Volunteers (YZ/YN) and Community Health Officers (CHO) operating in your paramountcy had any impact on health? What do you think has been the most important impact of the CHO and the volunteers living in the community?

Since the nurse came here, our health problems have reduced drastically. The only problem is the means of transport to carry seriously sick people and women in labour to the Navrongo hospital which is about 40 kilometres away. There are also no communication networks to call for assistance in emergencies. These are some of the issues that can be looked at in relation to facilitate the nurse's work. Generally speaking what we have benefited a lot from not only the nurse but also other health workers.

Your sub-district has a Health Centre. Did you really need CHOs and health volunteers in your paramountcy?

In the first place, the siting of the sub-district clinic at Biu is wrong. Biu is closer to Navrongo and can easily get down to Navrongo hospital. We are far from Navrongo and we have no means of transport. The nurse is the only means of health service in the community so we need her here.



Community members do more than just look on as their health deteriorates

The results of the CHFP have been used to develop a national health policy. Generally, how do you feel about your contribution towards this development?

We are happy that we have been part of the concept that the Ghana government is adopting. We even realize that doctors from other parts of the country come here to learn from us and sometimes you bring them to Naga here for durbars. So we are proud about that.

A MATTER OF LIFE AND DEATH: KOLOGO PARAMOUNT CHIEF

Would you say the NHRC has had any impact on health in your paramountcy? Could you explain by giving examples?

The NHRC in particular, and in collaboration with the DHMT of the KND generally, has done well to improve our health. Children do not fall sick and die as often as they used to in the past. You can see that our women too are healthy. The six childhood killer diseases have almost been eradicated from our town. The Research Centre has also sensitised our people to practise FP, which has helped them physically, economically and socially. The distribution of insecticide-impregnated mosquito nets also reduced the rate of malaria infection considerably. So the NHRC has done a great deal for us in terms of health promotion in Kologo.

Did anyone from the NHRC come to talk to you about the CHFP? Can you describe the first such occasion when someone from the NHRC came to talk to you about the CHFP?

Yes, I remember quite well that it was Dr. Amankwa [now Regional Director of Health Services for the Upper East region] and other staff from the NHRC who came to talk to my elders and me.

What was discussed at the time?

It all centered on health and how they wanted us to put our heads together to see how we could improve health in Kologo. I remember very well in those days things were hard—there was widespread hunger, there was no food and no money. We could not send our children to school and when they fell sick it was a matter of life and death.

What were your immediate impressions?

We listened to them with keen interest and accepted the chance to cooperate with them to improve health in the community because after all it was for our benefit. So I advised my people to embrace the new ideas. The message about FP, though new to us, hit us the most because we saw clearly that things were becoming more and more difficult and FP could be a way out of a desperate situation.



A cross section of Navrongo Health Research Centre (NHRC) research scientists whose job it is to improve health indicators in the district



When it comes to health it's a round conference

A study has indicated that the ancestors are not averse to FP. As a traditional ruler, do you agree with this conclusion? Why do you agree or disagree with this conclusion?

I agree with what the ancestors said. This is because I know it is good to space childbirth so that they can grow healthy. We space crops when we are planting so we can apply the same principle for spacing childbirth.

Some workers report that there is community apathy about the CHFP. Do you agree with this assertion? What have you done to address such issues?

I do not think that there are some people from my community who are opposed to what the nurse is doing. I have been telling my people if the nurse gets to their houses they should give all the necessary cooperation for her to do her work. Her work is very beneficial to us and we like her.

Are there any aspects of health that you think have not been addressed under the CHFP? What do you think should be added to the programme?

What I would like to ask for is for the NHRC to give us one more nurse because the coverage area is just too large for a single nurse to operate in. I think what has been left out is transportation. The NHRC probably thought that

with the nurse in our midst we would not have any more complex problems but we do from time to time. It would also do us a lot of good if there were a means of transport so that we can get to the Navrongo hospital in good time when there is an emergency case. We think this is an aspect of the health referral system that the research people did not consider at the time but which has been revealed to be crucial in complementing the nurse's role. We sincerely hope that you would be able to do so not only for Kologo but also the rest of the district.

The results of the CHFP have been used to develop a national health policy. Generally, how do you feel about your contribution towards this development?

Our participation in the programme that has now become a national policy makes me feel happy. I am happy that this has happened and people even come here to study it.

What are you and your people prepared to do to advance the work of the resident nurse?

Anything we can do to help we will do willingly if anyone were to ask. If people are needed to do work for you, I will mobilize them. If you call me for a meeting anywhere, at anytime, I will be there.

PAGA WITHOUT BORDERS: PAGAPIO

You have been here long before the NHRC began. Has the NHRC had any impact on health in your paramouncy? Could you explain by giving examples?

The NHRC has had a tremendous impact on health in the whole district not just in my traditional area. There are a lot of examples. First and foremost that terrible disease, measles, seems to have been eradicated from our district I have not heard of any cases for a long time. It alone could have wiped out all our populations because we were helpless when it attacked. Malaria has also significantly gone down. It's still a killer disease but we just can't imagine how things would have been without the intervention of the research centre. Today mosquito nets are readily available at heavily subsidized prices for

pregnant women and children. But I think one of the most important achievements is that through the research work in the district our people have come to understand that health cannot be taken for granted.

Did anyone from the NHRC come to talk to you about the CHFP? Can you describe the first such occasion when someone from the NHRC came to talk to you about the CHFP?

Yes I remember very well though it seems so long ago. A message came from the research centre requesting a meeting with my elders and me. We all assembled here in the palace.

What was discussed at that time?

A team came and we discussed health matters generally and then the research team informed us that they were coming to consult us to see what ideas we had with regard to effective ways of improving health care delivery. We put our heads together and came out with suggestions. They said since we were not sure what was the best thing to do we should try out the ideas that came up in an experiment.

What were your immediate impressions?

We were excited about it because we had already worked with the research centre and knew quite well what they were capable of doing. They had already tried out a few ideas that worked well; others from far and near are now emulating these examples. But I must confess that some of my people were not very clear about how the health volunteers were going to work. Now so many years down the line we have seen that some of the fears have been allayed.

Some workers report that there is community apathy about the CHFP. Do you agree with this assertion?

What have you done to address such issues?

I am not aware that there have been any disagreements between health volunteers and community members. The people are generally satisfied with the volunteers and they try to facilitate their work in whatever way they can. I am



The Pagapio ensconced in his regal seat but in touch with his community

aware that some community members tend the gardens for health volunteers as a way of showing appreciation.

Have Health Volunteers (YZ/YN) operating in your paramouncy had any impact on health? What do you think has been the most important impact of the health volunteers living in the community?

The most important thing about the health volunteers is that they are available day and night to provide treatment for minor ailments such as headache, abdominal pains, diarrhoea and so on. In the past if one were taken ill in the night you were at the mercy of the disease. But now the health volunteer is close by. He or she will offer first aid and manage the illness until the sick person can reach the nearest health centre.

A study has indicated that the ancestors are not averse to FP. As a traditional ruler, do you agree with this conclusion? Why do you agree or disagree with this conclusion?

As a matter of fact FP is nothing new to us. Our people have practised FP since time immemorial. So our ancestors are right. In their time, a woman would normally give birth to a child at four- to five-year intervals. High infant mortality made it almost impossible to maintain that standard. But now more and

more children are surviving so natural methods may no longer be enough.

Are there any aspects of health that you think have not been addressed under the CHFP? What do you think should be added to the programme?

Well, nothing really that I can think of. I would just like to remind you that my traditional area is yet to receive community health nurses who have been sent to live and work in other communities. Even though the volunteers are doing well, if they work together with nurses I think that health would improve remarkably. I also think you need to intensify your message and make your presence felt in some of the most remote villages such as Kulya.

Your sub-district has a Health Centre. Did you really need health volunteers in your paramountcy?

Yes we needed them and we still need them. They are a vital part of the health care system. They help in the detection of diseases and epidemics in the communities. They play a vital role in immunization campaigns. But I think it is their role as health mobilisers that makes them really important. They seem to be working well with the health centre staff too.



Working with communities to establish credibility for health research

The results of the CHFP have been used to develop a national health policy. Generally, how do you feel about your contribution towards this development?

We are very proud about it but as you know, this is not the first time something good has come from the research centre to help others. I remember the Vitamin A project and then the Bednet study. The results of these projects are being used for the benefit of others in Ghana and even in other parts of the world. I am very proud that a poor and deprived people like us have been able to achieve such great things for improving the health of people in other parts of the world. I would like to urge the government to pay serious attention to the work you are doing and provide you with all the money and other forms of assistance that you need to continue.

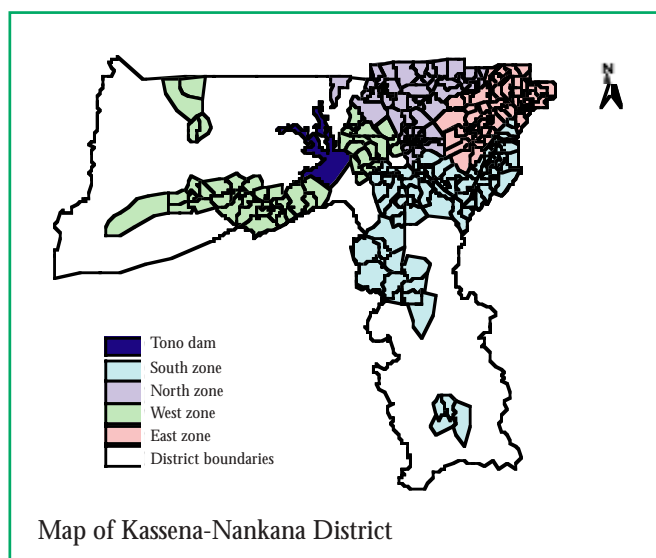
Volume 4, Number 12, 2004

HIV: SOUNDING THE ALARM!

The CHFP tests the hypothesis that improved health care delivery can induce a demographic and health transition in rural Ghana. Will the high and rising HIV/AIDS prevalence rate in the district impede CHFP efforts in programme outcomes? If so, can community mobilisation strategies be an effective tool for changing health-seeking and sexual risk behaviour to stem HIV transmission in the population?

It is often said, “ignorance is bliss.” Indeed, sometimes it is good not to know however, more often than not, the truth eventually has a way of showing up, often to the confusion of those concerned!

The HIV/AIDS situation in the KND is still to be unravelled. We have only recently started to come to grips with a rapidly worsening problem. The little we have learned about HIV/AIDS in two years is probably too small to start calling it a crisis. However, the alarm bells must start sounding and must be heard even in the most remote parts of the District—Kayoro, Nakong, Kulya, Biu, Naga, Yua, and beyond! Bad news is always news, and if a leap from an HIV prevalence rate of 2.4%



to 5.1% within twelve months is not news then we may have to look at our definitions again!

Since Ghana first documented her first HIV-positive cases in 1986, the country has come a long way from the days when most of the recorded cases were people living outside the country or women. What probably hasn't changed is the stigma attached to the condition, which appears to have deepened over the years as people increasingly see and hear of people living with HIV/AIDS. The plethora of adverts on national TV and radio asking people to show compassion for people living with HIV/AIDS is enough indication that there is a fight to be fought on that front.

One of our major problems as a developing country is about being able to collect accurate data to reflect existing situations. It is no secret that hospital data grossly underestimates the burden of disease and mortality in Africa south of the Sahara. Many people who suffer chronic illnesses do not attend hospital, for reasons relating to, among others, accessibility, belief systems, and disease causation. As a result, hospital data cannot be relied upon to give reasonable estimates of the extent of the problem of HIV/AIDS. The sexual transmission of HIV further worsens the situation as many people continue to associate the disease with prostitution and sexual immorality.

The National AIDS Control Programme (NACP) quickly realised that hospital records are but a tip of the proverbial iceberg! The long incubation period of the HIV virus also means many people are living with the condition but are well and do not need to go to the hospital. These people are not likely to be captured by hospital records. This lack of accurate reporting led to the initiation of the National Sentinel Serosurveillance Programme in 1990.

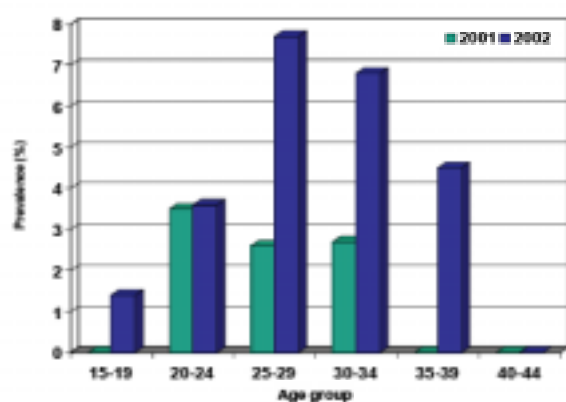
Estimates of the prevalence of HIV in the sentinel populations tested have been obtained. Trends of the disease in these populations have also been monitored over time. The data obtained has helped to provide information to evaluate the HIV/AIDS prevention and control programme. Most of the sites used for the survey only test pregnant women. However, two sites have been used for testing STD clinic patients as high-risk populations.

Blood used for HIV testing is obtained in an unlinked anonymous way, that is, after the routine laboratory tests for which blood was originally drawn have been completed and all personal identification has been removed. This programme has opened our eyes in Navrongo. Inaction on our part has potentially far-reaching effects that could undermine the lofty achievements of the NHRC and even affect projects being envisaged such as vaccine trials.

In 2001, Navrongo was added to the list of sentinel sites for HIV testing. In that year, HIV prevalence among pregnant women was 2.4%. This was below the then national average of 3% but higher than the average for northern Ghana of 1.6%. Among the 23 sentinel sites, that figure put Navrongo at the 17th position on the league table, barely escaping relegation!

Then the bombshell! In 2002, the prevalence of HIV among pregnant women shot to 5.1% and significantly moved Navrongo up to the unenviable position of number six on the league table. This is alarming and most worrying because in spite of the impressive gains made by the CHFP in reducing fertility and childhood mortality, the CHFP has not halted the onset of the HIV/AIDS. Full effects of the CHFP are unknown,

however, because prevalence trends are not available by treatment. Nonetheless, the trend for the district as a whole is cause for concern. It is known that some of the worst hit countries in southern Africa experienced explosions of their HIV prevalence when they started going beyond 5%. This is because when prevalence exceeds 5% the epidemic starts to spread more in the general population, beyond high-risk groups. This is the new situation that is suggested by current trends. Some facts clarify the course of the upsurge, although it is too early to conclude that there is a definite acceleration of trends. For example, all cases are HIV-1, the type found elsewhere in the country; none of the positive cases has been HIV-2. The age group with the highest prevalence in 2002 was the 25–29 year age group, which mirrors what is found on the national scene. In 2001, there was no positive case among the 15–19 year age group. However, one positive case surfaced in that age group in 2002. The implication of this is not yet known. Is the initial detection of HIV among youth an indication of trends to come? Fears have always been expressed about potential problems associated with HIV/AIDS owing to certain prevailing characteristics in the district. Already the district is grappling with malaria, cerebrospinal meningitis, filariasis, schistosomiasis, occasional outbreaks of anthrax, and other health problems. Who needs this “spirit child” added on?



Results for Navrongo from HIV Sentinel Surveillance Survey, 2001 and 2002

Navrongo happens to be close to Paga, a busy border town. In recent times, there has been a high influx of human and vehicular traffic across the Paga border as a result of increasing political instability in Ghana's neighbouring countries. Notably all three neighbouring countries have HIV prevalence rates that are much higher than Ghana: the Ivory Coast 10.76%; Togo 5.98%; Burkina Faso 6.44%; as against Ghana's 3.0%. Political instability and changing patterns of commerce and road traffic between Ghana and her neighbours may be conspiring to change the epidemiology of the disease in Ghana. More needs to be done to understand the onset of this epidemic in border areas. We need to prevent further transmission of the virus and we need to take care of people who are already infected. As researchers, we need to look at the various interventions being implemented across the country and see how we can assist to make them achieve the most impact.

We need to ensure that young people delay their initiation of sexual activity and for those who have already set sail, encourage them to practise safe sex. The Adolescent Sexual and Reproductive Health project has these as some of its objectives and if success comes our way as we hope it would, then the “window of hope” can start to become a reality. A major headache will come from adults who have already adopted enjoyable bad habits, which are difficult to give up. It will require deep thinking and innovative ideas to get such people to adopt healthier sexual behaviours. One of the most important things to be done is to start a Voluntary Counseling and Testing (VCT) programme. The NHRC will soon begin a programme of research using lay counselors and Community Health Officers in the community for a VCT programme.

Conclusion

The activities of the CHFP have improved community health, but HIV-prevalence monitoring results indicate that there is now a need for a new project with a focus on finding community strategies for HIV/AIDS prevention. Can community entry and mobilization strategies become

an effective tool for changing health-seeking and sexual risk behaviour? This should be the subject of experimentation by the NHRC in the near future.

Volume 4, Number 8, 2004

WOMEN SPEAK, MEN LISTEN

Under the CHFP of the NHRC women have stated their preference for spacing childbirth. But has this stated preference also translated into a desire to limit fertility? How far down the road have we come in terms of bringing down fertility levels? Statistics on a study conducted among 8,998 currently married women follow.

High fertility in Sahelian West Africa represents a continuing issue for population policy. Fertility levels in the region are double the levels observed across the developing world. Although some coastal cities have witnessed a reduction in fertility levels, the rural hinterland of West Africa has yet to enter the global fertility decline. Many respected observers have emphasized the resilience of pronatalist social institutions in this region in noting that African religious customs, lineage and descent systems, kinship networks, and family structure reinforce high-fertility social norms, beliefs, and values. In this view, high fertility reflects the desire for children, and improving access to FP services will have little or no fertility impact. Despite the climate of scepticism about the demographic role of FP services, most reproductive health and population programmes in the Sahelian region focus on improving accessibility and quality of FP services. Other researchers in the world have concluded that existing demand for services is sufficient to bring about a reduction in fertility if services are provided. In other words, it is widely assumed that making FP services available in community locations will inevitably lead to increased use of contraception and reduced fertility. The CHFP project of the NHRC tests the relative effectiveness of alternative strategies for achieving increased contraceptive use and low fertility. The CHFP represents a test of the hypothesis that

reproductive ideational change can be introduced in a traditional African society. This note summarizes findings from a study that assesses the impact of experimental intervention on current use of modern methods and on fertility.

Launched in 1994, the CHFP is a two-phased programme of four experimental research cells in the KND. Three of which are new basic primary health-care and FP programmes instituted in addition to the standard clinic-based services provided by the MOH. The fourth cell maintained the standard services only and is used as the comparison area of the project. Cell 1 comprised of the *zurugelu* intervention which involves mobilizing traditional social institutions in health delivery and planning. This approach, which is based on volunteerism, promotes the idea that managing health care resources and providing revolving funds for primary health care drugs and services through community volunteers can be a sustainable means of achieving Health for All. The volunteer's main task is to sell the CHFP idea to the community, particularly to men who exert considerable influence over decisions about women's mobility to seek health care.

Cell 2 consists of a health service mobilisation intervention which tests the effectiveness of improving access to Community Health Officers (CHO) by reassigning them from sub-district clinics to



Expanding family planning choices for women in community locations leads to increased use of contraception but may not result in reduced fertility

community-constructed residences, known as Community Health Compounds (CHC), and equipping them to conduct door-to-door health services. Cell 3 is the combined intervention area the *zurugelu* and CHO approaches are pursued simultaneously. This intervention tests the premise that the *zurugelu* and MOH mobilization interventions are complementary and synergistic. In the combined treatment area, close collaborative links have been established between health volunteers and the CHO.

A study which assesses the impact of the CHFP on contraceptive use and fertility reduction was carried out on a total of 8,998 currently married women gathered in an average of 2.4 panel years (from the CHFP panel surveys) for each individual over a maximum of six panel years. Each observation in the data set represents one year of panel responses from one woman. The analyses used six panel data sets compiled in 1993 as a baseline and subsequently through 1999 in order to assess the impact of the experiment on fertility behaviour and preferences. The 1994 panel was not used because it did not collect data on the background characteristics that are of interest in the study. Several descriptive and statistical procedures were employed in the analysis with estimates of the impact adjusted for underlying differences between experimental cells in fertility-related behaviour. The findings of this study can be summarized as follows:

- Educated women and women who no longer practice traditional religion are each associated with an increased likelihood of knowing about a modern contraceptive method. In addition, these women are also more likely to know a modern-method source, more likely to prefer limiting childbearing, and more likely to use a modern method. This finding may indicate that such women are more likely to exhibit nontraditional fertility behaviour.
- The desire to space childbearing is approximately two times greater than the desire to limit fertility, a finding that is consistent with other research conducted in the Sahelian region. The prevalence of the expressed desire to space the next birth rises



Women are still looking for the right balance between desire for child spacing and desire to reduce fertility

from 42% among all women in 1993 to 59% for women receiving combined exposure or no exposure in 1999, and 57 and 52% for women receiving *zurugelu*-only or nurse-only exposure in 1999.

- The central finding is that *fertility can be reduced by one birth in three years of FP programme exposure*. Each arm of the experiment has had modest, but significant fertility effects that compound when different approaches are combined into a comprehensive community mobilization strategy.
- Although the CHFP has induced reproductive change in KND, contraceptive use is clearly not the only fertility determinant responsible for fertility declines in the district or the entire upper East region. In 1998, fertility declined markedly in all areas of the district including the comparison area, but the determinants of this change were dominated by abstinence and delayed marriage rather than by increased contraceptive prevalence.
- Minor or temporary lapses in programme intensity can lead to widespread discontinuation of contraceptive use. Just as women respond to convenient services when nurses live in villages and conduct home visits, they readily abandon contraception if programme support is disrupted.

- The impact of the project is distributed across all age groups and fertility results suggest that all cells are experiencing an impact from the CHFP. In addition, the combination of the nursing-outreach and the *zurugelu* activities caused the greatest impact. Therefore, the relative effectiveness of the combined strategies attests to the need for a balanced, gender-sensitive approach to developing male participation.

Conclusion

The results reported here lend support to the hypothesis that the Navrongo experiment induced reproductive change in KND. Implementation of the project has made contraceptive and FP services more readily available than in other rural areas in northern Ghana, and project activities may have fostered reproductive attitudes and behaviour that differ from those in communities where clinical services are more remote and community outreach is less developed. If the current treatment differentials are sustained and amplified, project hypotheses will be upheld. Thus, these results provide evidence that a supply-side programme can have an impact, even in a rural traditional setting that is widely viewed as being incompatible with FP programme success.

programme is the last word on who is right and who is wrong in the FP debate.

The Navrongo experiment was designed to provide a basis for understanding the process of reproductive change by measuring the relative impact of different types of health delivery strategies in a rural community in northern Ghana. Baseline characteristics of the population of women of reproductive age and their husbands were documented. Follow-up panel surveys and a longitudinal demographic surveillance system monitored changes in contraceptive knowledge, reproductive preferences, reproductive behaviour, and fertility. Four cells represented different health service delivery strategies. The bureaucratic approach of the MOH focused on static facility health care delivery under which basic resources were lacking, community mobilization and supervising systems were weak, and community accountability was rarely developed.

The CHFP introduced a nurse outreach arm involving the deployment of a community-resident nurse CHO to provide doorstep and compound-specific health care. This approach bridged social distance between service provider and client, thus making services user-friendly. The *zurugelu* arm mobilized community-level cultural resources to organise health care delivery. This approach involved constituting health care action committees from existing social networks, and

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FERTILE GROUNDS FOR RESULTS

Some “experts” from distant lands claim that FP cannot work in rural Africa. According to this argument, fertility has always been high because that is what people want. But, surveys show that women often say they need FP, even though they are not using it. These results suggest to other “experts” that if unmet need for FP is met with quality services, fertility will decline. But, when experts disagree, one wonders if they are experts at all. The CHFP experiment makes men and women in communities the true experts. Their response to the

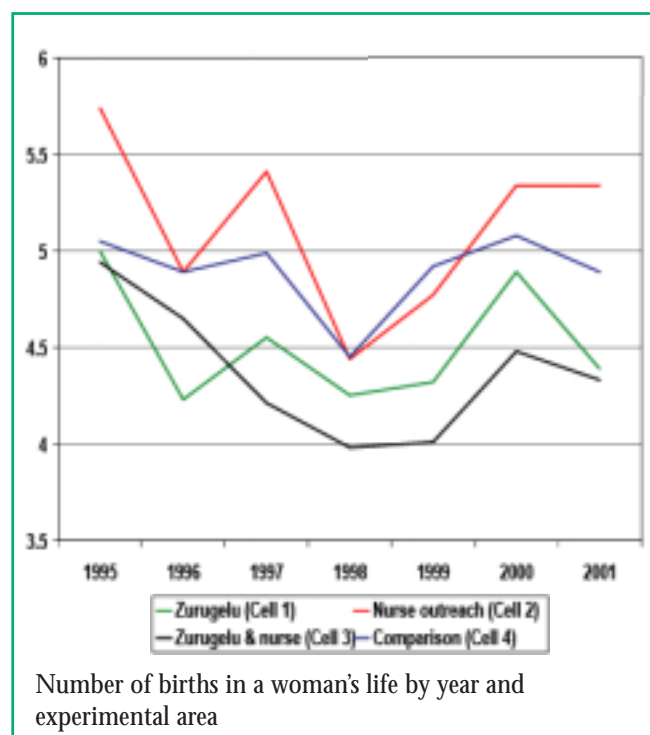


Merely making family planning convenient is not enough to bring down fertility; community entry, mobilization, and male participation are essential to success

implementing supervisory services with active traditional village self-help schemes. Services were provided through the use of community health volunteers chosen by the community and trained by project staff to provide basic health care services, reproductive health education, outreach to men, and contraceptive supplies. Outreach to men was undertaken by community gatherings known as *durbars* at which discussions focused on health and FP themes to give men an open forum to discuss their reactions to the programme. The gender strategies and communication activities of the *zurugelu* arm of the experiment were expected to alter the social context of reproductive change by seeking the support of men for the concept of FP, by opening community dialogue about health and reproductive matters that traditionally were not discussed between spouses, and by involving women in social leadership that previously had been the monopoly of men. The third arm of the experiment combined nurse outreach services and the *zurugelu* approach. The hypothesis to be tested was that the social costs of contraception could be reduced through community mobilization and more readily available client FP provision.

Results are coming into focus. When the CHFP started, it had an immediate impact on knowledge of contraception. FP use increased, but only in areas where nurses were posted in combination with *zurugelu* activities. Making FP convenient is not enough. Community entry, mobilization, and male participation are essential to success. But, *zurugelu* activities without nurses is also not enough. Women require comprehensive and convenient services, and volunteers distributing a single method does not meet their needs. Putting it all together—with volunteers working closely with nurses, communities mobilized, chiefs on board, and health services well developed—FP can work, even in KND where traditions are strong and the role of FP is debatable.

These conclusions are demonstrated by the trends in the figure below. In all cells of the experiment, women were having, on the average, five children in 1995. Where there have been no CHFP activities—only clinics—fertility declined by a half a birth in 1998, but



then returned to baseline levels by 2001. This pattern was also followed in the “nurse only” area, which had even higher fertility throughout the study period. But, where *zurugelu* activities were introduced, fertility decline is evident, and where nurses and volunteers work in the same communities, fertility decline was pronounced—from five to four over the 1995 to 1999 period, although increasing in 2000 to 4.5, and then declining again in 2001. Fertility has changed yearly in all study areas, but where treatment activities are most intensive, the programme works.

So, a general conclusion is evident from the CHFP: Despite the inauspicious social and economic context for reproductive change, the CHFP has had an impact on fertility. In rural Ghana, where traditions of chieftaincy, lineage, and consensus-building remain vibrant, outreach to key male leaders and mobilization of their networks can put men at ease about FP, and can ultimately determine whether or not women can exercise their preferences.

Caution is nonetheless warranted. While fertility impact has been achieved, results changed as the programme progressed. As the figure shows, the impact

was less in 2000 and 2001 than in 1998 and 1999. While the CHFP has worked, the reservations of some sceptics are well founded. But, while results are not huge, impact is much greater than many experts expected.

Volume 4, Number 12, 2004

THE DYNAMICS OF CHANGE

In 1994, the NHRC through the CHFP began to develop an innovative system of health care delivery that would bring doorstep community health and FP services to residents of an impoverished, rural traditional locality of northern Ghana. The CHFP tested two main arms of service delivery: mobilizing community leadership structures to select *zurugelu* (togetherness) health volunteers within each village, and mobilizing communities to construct Community Health Compounds (CHC) and homes for Community Health Officers (CHO) who relocate to individual villages and provide doorstep services on motorbikes. These two strategies are tested separately and together, forming a four-cell experiment that tests the health and fertility effects of these three strategic components versus a comparison area receiving normal clinic-based services provided through the MOH throughout Ghana.

Findings from the first four years of full-scale implementation (i.e., 1996–1999), suggest that while contraceptive use increased in all three experimental areas over time, the only momentous rise in contraceptive use relative to the comparison area was found in Cell 3, the area with combined nurse outreach and *zurugelu* service. However, current contraceptive use is relatively high in Cell 1 the area receiving *zurugelu* services only as well. Researchers interested in women's contraceptive use are always concerned with whether they continue or discontinue use. Continuation of contraceptive use ultimately is expected to reduce fertility whereas discontinuation is always a matter of concern. An important question to ask is “how does contraceptive discontinuation occur? It occurs because women want to have another child, because they are having a physiological

problem with a particular method, or because the social or monetary cost of continuing contraceptive use is unsustainable. In the context of KND, the hypothesis is that services offered by the CHFP lower discontinuation rates via two mechanisms: by affecting demand for contraception (which enhances the desired to practice tenaciously through increasing desire for limiting or spacing number of children), or by reducing the perceived constraints on practising contraception (such as psychological factors preventing effective contraceptive use including fear or experience of side-effects and social pressures against use).

CHOs and *zurugelu* volunteers are expected to affect contraceptive continuation differently. It is expected that CHOs would be better than the *zurugelu* system at assisting women to manage psychological and perceived health costs or side-effects. CHOs can provide contraception at the doorstep and at convenient community locations; *zurugelu* volunteers can only refer women to relatively inaccessible sub-district clinics. *Zurugelu* volunteers are expected to increase contraceptive continuation rates by helping to decrease the social costs of contraception.

A study was conducted that examined contraceptive use (all methods except condom) dynamics in all four cells of the experiment, in order to investigate differences in services provided by CHOs and *zurugelu* volunteers. Contraceptive use dynamics are assessed only for modern methods because these are the methods promoted by *zurugelu* and CHOs. Researchers categorized the modern contraceptive status of women in the 1996–2001 Navrongo panel surveys based on their modern contraceptive use in previous years. Over the 1996 to 2001 period, there were 23,534 observations of 7,879 individual women who had been observed in the previous panel year. Most women were observed several times, with an average of three years each. Here is a summary of findings from this study.

- Relative to the comparison area, current use of modern contraceptive methods in each of the four cells reveals that use is highest in the *zurugelu* area followed by the combined area and the nurse outreach area.



The 'Injectable' becomes a family planning method of choice for rural women

- The combined exposure area has the greatest frequency of use among women who weren't using in the previous year and the comparison area has the lowest modern contraceptive incidence. Incidence in the CHO area appears to be gradually rising while incidence remains uniformly high in Cell 3 and uniformly low in Cell 4. New or resumed use fluctuates among women in Cell 1, the *zurugelu* area.
- The proportion of women who continue to use a modern method is lowest in the comparison area, Cell 4, where it initially increases from 29% to 49% and subsequently declines by 2001 to about 25%.
- Women in the nurse outreach area experience the highest continuation rates initially, with rates as high as 62% in 1998. Subsequently their continuation rates fall and rise again, to a level of approximately 53% by 2001. Women in Cell 1, the *zurugelu* area, have continuation rates that rise from 43% in 1996 to 61% in 2001.

A statistical procedure was employed to examine the continuation of modern method use in the current year among women who were using a modern method to avoid or delay pregnancy in the previous year. Results showed that:

- Initially, women exposed to CHOs had the highest contraceptive continuation—with a chance 3.8

times more likely to continue relative to women in the comparison area—whereas women exposed to combined treatment had a chance 2.6 times of continuing to use modern contraceptives relative to women in the comparison area.

- Contraceptive continuation among educated women in the three experimental areas is significantly higher than that of uneducated women in the comparison area—in fact, it is twice as high on average.
- Adoption of Depo-Provera is highest in areas with a CHO. Depo-Provera forms 89% of new or resumed modern method use among women in the nurse area, 77% of new or resumed use among women in the combined area, 68% of new or resumed use among women in the *zurugelu* area, and 67% of new or resumed use among women in the comparison area.
- Contraceptive continuation rates are highest among IUD users, followed by Depo-Provera users and pill users. This pattern is observed for women in each of the four cells. Women in the comparison area have the lowest continuation rate for each method compared with women in other areas. When women change modern methods, they are most likely to change to Depo-Provera—followed by the pill in all areas except the nurse outreach area. In that area alone, they are more likely to change to the pill.

Conclusion

The combined dynamics of modern contraceptive adoption and continuation explain fertility differentials in the contrasting exposure areas of the CHFP experiment. While the frequency of contraceptive use is the basis for fertility change, continuation of use is crucial for fertility decline to take place. Low modern method adoption rates among women in the CHO area and low contraceptive continuation rates among uneducated women in Cells 1 and 2 appear to explain the fertility differentials observed across experimental cells. Reasons for not currently using a contraceptive method given by women who have discontinued contraceptive use fail to shed light on differential

continuation rates in CHFP experimental cells. This merits further investigation.¹

Volume 4, Number 18, 2004

INTERACTION AND CONTRACEPTION

Although sub-Saharan Africa remains the only major region of the world with the highest fertility rates, fertility in the region as a whole is now noticeably lower than it was around the late 1970s or later. Discussions about the barriers to rapid fertility decline in this region have highlighted the nature of African reproductive regimes—particularly how they differ from reproductive regimes in other regions. The main consensus on African reproductive regimes appears to be that contraception is one of the key factors underlying fertility decline in Africa. Prominent among factors that have been identified to influence contraceptive use are fertility preferences, increased participation in formal schooling, urbanization, and the diffusion of modern Western culture. The role of diffusion in reproductive change has received great attention in the literature in recent years. Several studies in demography have investigated the role of diffusion in fertility transitions. Underlying these studies is the assumption that the information or behaviour of one person can have spillover effects (positive or negative) on the motivations of another.

Two essential components of diffusion are social learning and social influence. Social learning refers to the acquisition of information from others, which in the case of fertility control, may include information on the types of contraceptive methods available, the health side effects of the methods, and the cost of the methods. At the inter-personal level, social learning takes place when the

other actors provide information that shapes an individual's subjective beliefs about prices, qualities, advantages, and health risks of FP methods. Social influence, on the other hand, refers to the power that individuals exercise over each other through authority, reverence, and social conformity pressures. It is noted that individuals, faced with the need to make decisions in constantly changing environments characterized by ambiguities and uncertainties, rely on information drawn from many sources.

The CHFP of the NHRC tests the relative effectiveness of alternative strategies for achieving increased contraceptive use and low fertility. The CHFP represents a test of the hypothesis that reproductive ideational change can be introduced in a traditional African society. This note summarizes findings from a study that examined the impact of social interaction (measured by reports of a personal network member with whom FP has been discussed) on the adoption of contraception in the KND.

Launched in 1994, the CHFP is a four-cell experiment designed to evaluate the impact on a health service delivery programme of mobilizing two types of resources—the usual MOH resources and community participation in programme management. The resources are represented by the key staff at the periphery: the Community Health Officers (CHO) who are the MOH nurses relocated to village settings, and YZ representing community volunteers involved in health promotion.



Practitioners of nontraditional religions and women with formal education are more likely than others to adopt contraception

¹ Williams, John E., Elizabeth F. Jackson, Isaac Akumah, and James F. Phillips. 2003. "The determinants of contraceptive use dynamics in Kassena-Nankana district of northern Ghana." Paper presented at the Annual Meeting of the Population Association of America, Minneapolis, Minnesota, 1–3 May.

The four cells represent the different combinations of resources that are mobilized. Cell I has YZ only; Cell II has CHO only; Cell III has both CHO and YZ; and Cell IV has a normal MOH service delivery regimen, and is thus a comparison area.

A study which assesses the role of social interaction in contraceptive adoption was carried out on a total of 1,437 currently married women ages 18–49 in 1998 who had not adopted contraception by the time of the survey in 1995 and for whom valid values were available on all variables of interest. In this study, the key outcome variable of interest is contraceptive use in 1998. Contraceptive use has two categories: using at the time of the 1998 survey and not using. The principal explanatory variable is social interaction, measured by discussions of FP with other individuals and the contraceptive-use motivational role of such individuals as of the time of the survey in 1995. Social interaction is defined strictly in terms of discussions of FP with individuals other than the husband. In other words, spousal communication is excluded. Several descriptive and statistical procedures were employed in the analysis and the findings of this study can be summarized as follows:

- Generally, older women, women who live in areas with only the MOH services, practitioners of traditional religion, Nankam women, and women who have never attended school are more likely than others to have no social interaction about FP. In contrast, younger women, women who reside in areas served by the combined activities of the CHO and YZ, practitioners of nontraditional religions, and women who have had some formal education are more likely than others to have interacted with social interaction partners who encourage them to adopt contraception.
- Contraceptive use in 1998 is found to differ significantly by patterns of social interaction in 1995. Women who at the time of the survey in 1995 had discussed FP with partners who encouraged them to adopt a method are almost three times as likely to use FP as women who at that time had not discussed FP with conversational partners.
- Education is also positively correlated with contraceptive use by women who have some formal education being almost twice as likely as the uneducated to adopt contraception. Furthermore, the intervention programme of providing child health and FP services through CHO and YZ enhances greater demand for contraception.
- Women who have been encouraged by their discussion partners to use contraception are almost three times as likely as the 'no social interaction' women to adopt contraception. For every contraceptive user among women who have not discussed FP with social network partners, there are nearly two users among women who have discussed but have not been encouraged by their network partners to adopt FP.
- Spousal communication about FP and the encouragement received from health workers and voluntary associations have considerable effects on contraceptive use. Indeed, women who reported that they had been encouraged by health workers are four times as likely as women who reported no such encouragement to adopt contraception.



The provision of child health and family planning services through the community health officer and Yezura Zenna (YZ) enhances demand for contraception

Conclusion

Results from this study suggest that social interaction about FP triggers changes in contraceptive behaviour in the KND. Furthermore, for the majority of the women, the decision to initiate FP practice is facilitated by informal discussions with social network partners who encourage contraceptive adoption. This study points to the need for programmes to facilitate social interactions that permit free exchange of ideas and experiences among community members. In addition, programmes should be developed to minimize misconceptions about FP methods. Adopters should be adequately educated on the benefits and side effects of contraceptive methods as well as the management of these side effects.

Volume 4, Number 23, 2004

MAKING WHAT WORKS WORK

Dr. Abraham Hodgson, Director of the NHRC, discusses his work.

Which areas does the NHRC presently focus its research on and why?

The Centre investigates health problems facing the people of northern Ghana in order to advise policy decisions on possible interventions. Presently the centre focuses research in the area of infectious diseases such as malaria, diarrhoea, respiratory tract infections (RTI), and cerebrospinal meningitis (CSM). We also focus on reproductive health and culturally related problems like female genital mutilation. Malaria, diarrhoea and acute respiratory infections (ARI) are the top three causes of ill health and death in children in the Kassena-Nankana District. CSM, which occurs in epidemics, leaves in its trail a lot of death and disability. The district has one of the highest infant and maternal mortality rates and the lowest family planning utilization figures in the country. By addressing the above issues, we hope to improve the lives of people in the district and the sub-region.

There has been a lot of emphasis on the CHFP. Is that the first time that the Centre has fielded a project whose results have been used to formulate national policy?

Interestingly, this is the third time something like this has happened. As a matter of fact the first project that was run in this Centre, the Vitamin A Supplementation Trial (VAST), achieved similar results. VAST tried to find out the effect of repeated large doses of Vitamin A on child survival. Results of the study did show that if children were given Vitamin A supplementation their chances of survival would improve by 20%. This is now national policy. The MOH has incorporated Vitamin A into the Expanded Programme on Immunization (EPI) and all small children are given Vitamin A to improve their chances of survival. The second one was the Bednet Trial which investigated the health benefits of sleeping under Permethrin-impregnated bednets. This also showed that sleeping under treated bednets reduces the incidence of malaria and cuts down child mortality by 17%. Permethrin-impregnated bednets are now being vigorously promoted throughout Ghana as a result of the results from the study carried out here.

Dr. Abraham Hodgson, MB ChB, MPH, PHD, is Director of the Navrongo Health Research Centre.



Dr. Hodgson addressing the concerns of the people

Is the CHFP then just another research study whose results have informed policy?

The CHFP has its own unique features. The experiment studied the existing health delivery system and saw its deficiencies with the CHNs who sat in static clinics expecting patients to come for therapy. The project then redesigned the package and relocated the CHN, after some orientation, to live in the communities among the people to provide doorstep services. There was another component of the study which used community-based volunteers for service delivery, in a bid to see what effect this would have on health indices. The third arm of the experiment combined the relocated nurse and the community volunteers whilst the fourth cell which continued with regular MOH services, served as the control. This study has shown very impressive results especially in the combined cell of nurses and volunteers. Immunisation coverage improved sharply, family planning uptake rose and continued to rise steadily, fertility slumped, and infant morbidity and mortality fell drastically. This explains why the experiment is being proclaimed across the country as an effective way of improving access to health care for underserved populations.

Why do you think the CHO agreed to go and live in the villages?

We got the CHN to understand that if they remained at the sub-district health centres their services would remain forever out of reach of the very people they have been trained to serve. Of course there were some who saw relocating to the village as an experience worth going through. Fortunately for us, the first three CHO who volunteered to go into the community discharged their duties credibly and the impact on the health of the people was immediately visible. The other nurses took a cue from this. From that time on, everything seems to be going on well.

What made the CHFP succeed?

Many factors. First, the questions that were to be answered were critically reviewed. Secondly, the investigators of the project were very committed to the



Community members hold a round conference to discuss health issues

experiment. Thirdly, communities were deeply involved every step of the way. They identified with and took ownership of the project. As project consultants, the people knew what would work and what would fail they have been vindicated.

Is the Centre involved in scaling up the CHFP in the Kassena-Nankana District?

Our commitment to the people here is resolute because it is through their sacrifice that many people today enjoy efficient health care delivery throughout the country. Our immediate responsibility is to ensure that those who did not have the full benefit of the experiment receive services. We had foreseen that human resources would be a crucial issue so in collaboration with the District Health Administration, we launched the Day Community Health Nurses Training School initiative as an effective means of providing nurses for doorstep health care. The KND needs about 36 resident nurses but so far only 18 are deployed. We are working closely with the District Health Authorities to spread out in every community in the district.

How do you intend to tell the people in the district that the CHFP is winding up?

In reality the CHFP is not winding up it will not end because the work of the nurse and volunteers will continue in the communities as it has always been but

only this time services would be delivered under a national programme the CHPS Initiative. Nevertheless, we shall inform community members about the end of the beginning or the transition from CHFP to CHPS. This is an elaborate programme that has just started. We have to go through the same processes we went through at the start of the project. We would go round to all the chiefs and hold discussions with them. We would later hold durbars in the communities as we have always done, and clarify the results that have been achieved

under the experiment. Though people know the experiment has brought beneficial results they do not know the fine details. We would seek their opinions on how to sustain the gains recorded. We would also organise a dissemination durbar for all the chiefs, political, and health authorities in the district as well as other stakeholders, and present the experimental results and the way forward. During this forum, as with the others, people would have the opportunity to ask questions, make contributions, and seek clarifications.

Replicating the Community Health and Family Planning Project (CHFP)

Volume 2, Number 5, 2002

REAL PROBLEMS, REEL SOLUTIONS: USING FILMS FOR HEALTH EDUCATION

Introduction

The idea of using drama film shows to disseminate health messages to the communities within the Kassena-Nankana District (KND) was first proposed in 1998. Ms. Charity Assibi Bukari, the Yezura Zenna (YZ) Coordinator, thought about a more lively way of putting health messages across to the community. The initiative was embraced and the drama troupe of the St. John Bosco's Teacher Training College in Navrongo was asked to collaborate on film shows for health education. The College authorities and the drama troupe were ready and willing to take up the challenge and an agreement was soon reached for the project to begin. The two main objectives of this initiative were to maintain closer links with the communities, and to disseminate health information more effectively.

Drama can focus communication on themes that would be controversial to discuss in an open forum. Moreover, drama can portray everyday problems in a manner that ordinary people can identify with. But drama is expensive and unwieldy to replicate on a large scale. Filming provides a low-cost alternative to village drama that increases coverage and expands the audience. Using a projector powered by portable generators makes it possible to attract community members to evening viewing sessions. Crowds are large and the demand for "night durbars" is now apparent throughout the district.

How themes are determined

- Problems are usually identified from the field during community health officer (CHO), YZ/Yezura

Nakwa (YN) supervisory visits and community durbars and also from research findings and survey reports. A single theme is identified and a script is developed around the theme.

- The drama troupe conducts a number of rehearsals. The last rehearsal is normally done at the Navrongo Health Research Centre (NHRC) in order for the staff to appraise the performance. Comments and suggestions are incorporated into the final script after which shooting is only a few communities away. The drama is acted in Kasem and Nankam, the two main languages in the district.
- A community is identified in which to perform and film the final production of the drama. The Communication Unit is responsible for video recording onto VHS videocassettes.
- The videocassettes are edited and prepared for showing to other communities usually at evening durbars. A health specialist goes with the night outreach team to answer questions that may come up after people have watched the film.

So far, how far?

The first script had the title *Male Involvement in Family Planning*. This theme was deemed necessary because, from observation, it is mainly women who get involved in family planning, although they are not able to assert their reproductive choices. To succeed in family planning, men must necessarily be involved since they are the family heads and can prevent the women from accessing family planning services.

Male Involvement in Family Planning portrays two families. Members of family A do not plan their family and have more children that they can care for. Some of the children drop out of school, one teenage girl gets



Reel solutions to improving people's lives

pregnant while still in school, another takes to loose living and ends up contracting HIV/AIDS and succumbs to the disease, one boy takes to drugs and goes mad, and another resorts to armed robbery for a living and ends up in jail. There is general unhappiness and rampant quarrelling in the family. Family B, on the other hand, plan their family and are able to educate their children. The little they have is enough for all of them and an atmosphere of happiness and cheerfulness pervades the household. This film has been shown in Cell 1 to boost family planning messages given by YZ. It has also been screened in Cell 2 where CHO operate.

Two anti-female genital mutilation (FGM) scripts have been developed and filmed and are being used in the eastern part of the District where an intervention to eradicate the practice is taking place. Two other films currently being shown are:

The 'Spirit Child' This film is a direct attack on the practice among some communities to kill babies who are born with disabilities based on the claim that they are spirit children who would, if not eliminated, kill their mothers. In the drama, a child is born with a big head and twelve fingers. It is declared a spirit child and a spirit doctor is called upon to kill it before it hurts its parents. The baby is secretly sent to an orphanage for protection. The child grows up, completes his education, and becomes an Agricultural Extension Officer. He returns to work in his own village and supports his people.

The Story Is Told This film educates people on the HIV/AIDS pandemic—symptoms, ways of acquiring it, and how to cope with someone who has contracted HIV/AIDS. The main character who failed to stay faithful to his wife contracts HIV. He infects his wife and child who die. When he himself tests positive, he decides to educate the society by using his own life as an example.

Impact

These films—especially *Male Involvement in Family Planning*—are a tremendous success. Comments gathered during night outreach indicate that the shows have had an impact on both couples and the youth. Some suggestions have been made to include a scene in which parents advise their children to desist from engaging in premarital sex and remain faithful in marriage. People have also lauded the film as very educational and recommended that more films in that vein should be shown to communities. Men have reportedly gone to YZ with their wives to request family planning services. During one session an old man was apparently overwhelmed by what he saw and expressed sentiments interpreted as regret: *"The film is very educative. Unfortunately it is too late for old people like me. I will make it a point to get my children, both boys and girls, to practice family planning and have just the number of children that they can adequately take care of. Things are*



Taking advantage of the darkness to get health messages across to the community



Play-acting is serious business

rather difficult these days... Others have not been so enthusiastic about our efforts. They have expressed disagreement with the promotion of family planning services accusing health workers of assisting their wives make reproductive choices without the knowledge or consent of their spouses. These concerns may be genuine but when the weights are put in the scales, the promotion of family planning seems worthwhile and the idea seems to be steadily gaining acceptance in the district.

Challenges

Even though the authorities and officers in-charge of the drama project are doing their best, there are a few challenges to overcome.

- The night outreach crew confronts difficult terrain, which is made even more difficult because of night travel. A video van, instead of a pick-up truck, is needed to appropriately transport, protect, and prolong the life span of the video equipment
- Some communities are often not punctual so the night outreach programmes do not start on time—causing programmes to go deep enough into the night that community members become too tired to ask questions at the end of the show. A solution is sought to this problem so that the full benefit of these night outreach sessions is reached.

Conclusion

The KND has recorded favourable indicators in health. More couples than ever before go to family planning clinics for advice on how to plan their families. The practice of FGM is on a steady decline. The films have obviously had some influence on the audience but the extent of this impact cannot be stated in categorical terms until an impact assessment in the experimental area has been done. To improve the quality of the films community members should be co-opted into the cast and also given the opportunity to view dry runs and give input before the final filming.

Volume 2, Number 22, 2002

WHERE DO WE GO FROM HERE?

Introduction

The Ministry of Health (MOH), the Ghana Health Service (GHS), and the ultimate beneficiaries of excellent, accessible, and affordable health care now know what works and what fails in reorienting health service delivery at the periphery. The Navrongo Community Health and Family Planning Project (CHFP) has proved that retraining and redeploying community health nurses (CHNs) to live and provide doorstep services in rural settings widens access, reduces cost, and improves health care delivery. Thus the desire of the Government of Ghana to achieve the long-term goal of growth and development for its people is being met. This desire is captured in the vision 2020 document which has identified five main areas for priority attention in the medium to long term. Among them is maximizing the healthy and productive lives of people. The Medium Term Health Strategy (MTHS) towards vision 2020 sets the direction and provides a framework for guiding reform and development in the health sector. It describes how the health sector can contribute to the improvement of the health of the people. Notably among them is strengthening the human resource planning, management, and training as a means of providing and retaining adequate numbers of expert and well-motivated health teams to provide services (MTHS 1999).



Infants look up to policymakers to make the right decisions about bringing down mortality figures

Two major problems associated with human resource development have been the overextension of already inadequate numbers of staff as well as uncoordinated training not related to priority needs. Addressing these problems calls for guidelines that would give priority to peripheral human resource training and distribution, with an appropriate mix to provide services. The objectives of the MTHS are to provide universal access to primary health services and improve quality as well as foster linkages with other sectors. Strategies outlined in the MTHS document aimed at achieving the above objectives include reprioritization of health services, expanding existing facilities, evaluating the possibility of starting new training institutions, and changing the nature of training to reflect the needs of the new health service.

Despite tremendous improvements in the health status of the ordinary Ghanaian over the years health for all is only now in sight. The state of the Nation's report (2000) indicated there are still significant variations between regions and between the urban and rural areas. For example, while the national average of infant mortality is 66/1000 live births, that of the Upper East Region (UER) is 105/1000 live births. This figure is even higher in the districts. The IMR for the KND was 124/1000 in 1995 (Binka et al. 1999) and the MMR is currently estimated at 600/10000 (Ngom et al. 1999). Under-five mortality in 2000 was 153/1000 falling to 116/1000 in 2001 as against the national average of 110/

1000 and 95/1000 respectively according to the Ghana Living Standard Survey 4 (GLSS4). The second Five Year Programme of Work (5YPOW 2002–2006) with the theme “Partnership for Health Bridging the Inequalities Gap” seeks to do more to address these problems.

The Ghana Poverty Reduction Strategy (GPRS) has also identified deeper inequities in access to quality health services in the four most deprived regions of Ghana. The UER remains the most deprived among the four with poverty levels well above the national average. Among the many objectives of GPRS is the goal to increase access to quality health services.

The ruling New Patriotic Party Government's manifesto on public health states that government will ensure that at least a CHN is located in every hamlet of the country. It goes further to indicate that more CHN shall be trained to carry out the campaign against malaria, typhoid, and STDs including HIV/AIDS. All these objectives can only be achieved when schools are set up to train more nurses to take up responsibilities.

The national picture and the Community-based Health Planning Services (CHPS) Initiative. At Ada-foa in August 1999, the directors of the MOH gathered to discuss the logistical implications of scaling up the project. In the course of this meeting, the Director of Human Resources, Dr. Ken Dagoe, noted, among other things that one of the major challenges that scaling up will face is acquiring the numbers of CHNs required by districts to implement the programme.

Staff refusing postings. At present, national nurse training facilities seek applicants from a national pool of eligible women. Eligibility is defined by schooling level—Senior School Certificate of Education (SSCE) or General Certificate of Education (GCE) graduates with credits or passes in English, Mathematics and Science. Trained nurses are assigned to a regional staff pool and are posted and distributed from the Regional Health Administration. This design of the programme is associated with problems that further constrain the availability of nurses. Individuals posted to a community are often from another ethnolinguistic group. Language deficiencies diminish work effectiveness and morale. Lack of social amenities, good schools for their children,



The way forward is to find an inexpensive and sustainable way to train more nurses for doorstep health care

opportunity for career progression, and family commitments compound the problem. Moreover, the procedure that is used does not adequately involve communities in the selection and posting of nurses. As outsiders posted to the communities, CHOs require extensive system support to enable them to build community knowledge, trust, and participation in the health programme. The use of outsiders also elevates the requirements of residential quarters, since nurses assigned to communities are far from their homes and families. Use of local, trusted, and well-trained nurses would obviate the need for the payment of village hardship allowances and other measures that make community residence palatable to the CHO involved in the programme.

The problem of numbers. The UER is characterized by dispersed settlements, seasonal flooding, and inadequate roads, making it hard for health workers to reach various communities. It is listed as one of the most deprived regions in Ghana and experiences a growing shortage of health staff. There are five CHN training schools in the country with an average intake of fifty students each per year. As a consequence, no more than ten CHN are posted to the region annually, and for the past five years the number of CHN providing services in the region declined from 200 to 97 because attrition far outpaces the arrival of new nurses. With the current level of service coverage, the region presently has a staff shortfall

of 40 percent, a dilemma that will grow unless action is taken to address the problem. The population of UER is 917,251 (2000 census) living in 475 communities giving an average of 1 CHN per 9897 people and 1 per 5 communities. These numbers are woefully inadequate if the inequalities in health are to be bridged.

It is clear to all planners that individuals seeking positions as CHNs are not in short supply; rather, the causes of the low numbers of nurses in the districts are threefold: attrition of trained nurses to higher grades as staff registered nurses within the GHS; attrition outside the health profession due to burnout or other personal reasons related to marriage and family, other economic opportunities and, lateral movement into health NGOs and private sector roles.

The acute shortage of CHNs across the country is exacerbated by the fact that the capacity to train replacement nurses is very low. At present, the annual output of nurses is barely sufficient to sustain current numbers and is far below the extra 2000 additional nurses that are required for the CHPS programme.

In the Ada-foa meeting, discussion of possible solutions to the problem of the shortage of CHNs focused on the need for every region to have a training school for CHNs. Lack of resources stifled this initiative from the periphery. But the issue cannot be shelved anymore and the way forward is to find cost effective and sustainable means of providing the required numbers of nurses for the CHPS programme.

Volume 2, Number 23, 2002

POOLING RESOURCES, PULLING TOGETHER

The KND is leading the way in establishing an effective and sustainable system of providing CHNs in support of the national CHPS. The District is starting a Day CHNs Training School in Navrongo. Scarcity of nurses has earlier been identified as the biggest obstacle impeding the effective operation of door-to-door health service delivery. The Navrongo plan is a collaborative work

between four identifiable stakeholders who have combined their forces.

Navrongo Health Research Centre (NHRC)

The NHRC has a pool of social scientists, computer scientists, public health nurses, reproductive health practitioners, and communications specialists from which teaching staff for the school will be drawn. The Centre has a library, which will be upgraded for student use. A canteen is also available at the Centre's premises and students will be allowed to use this facility. Computer sessions will be arranged in the Centre for students.

District Health Management Team (DHMT)

The DHMT will offer office space; team members will participate in the training and supervision of trainee nurses.

District Assembly (DA)

The KND Assembly will facilitate the acquisition of land as well as sponsor some students from the district. The Assembly will also engage student tutors from tertiary institutions to provide extra study for students to enable them to pass their final examinations and qualify for admission into the school.

Traditional authority

The chiefs and elders are very interested in the idea and agreed to take girls' education seriously; they will release land for the construction of permanent structures for the school.

Strategies

Consultative meetings. Consensus-building meetings have been arranged with the Regional Minister, the District Chief Executives, Coordinating Directors, DHMT members in the region, and other stakeholders. Meetings will also be held with the Nurses' and Midwives' Council to solicit their views and guidelines for setting up the school. Personnel from the Council will be invited to Navrongo to meet with the Regional

and District health directorates as well as the DA and inspect the school premises.

Study tours to CHN Training Schools. Visits aimed at interacting with authorities and developing lessons will be paid to Esiamah in the Western Region where a school opened last year. Visits will also be paid to traditional nurse training schools such as in Tamale and Akim Oda.

Rehabilitation of existing structures. To minimize delay, an interim training facility will be borrowed from the DHMT and renovated for classroom, library, and office accommodation.

Orientation of teachers. Teaching staff will be oriented in teaching methods and subject content. Lecturers from the University of Cape Coast and resource persons on teaching methods will be invited for intensive orientation.

Acquisition of Teaching/Learning material. Requisite teaching and learning materials are to be identified with the assistance of the Nurses' and Midwives' Council. Regional and Central Medical Stores will be the main sources while Cooperating Agencies remain a potential resource.

Curriculum development and entrance examination. The same curricula used in the traditional Community Health Training Schools will be used with modifications to emphasise increased fieldwork and practical experience. Since the entrance exam for 2002 has already



Working together works—stakeholders sharing ideas on the Navrongo Day Nurses Training School

been conducted by WAEC, regional candidates will be recruited who previously have not been granted admission to Tamale or other schools due to lack of space. If the required number of students has then not been met the Human Resources Directorate (HRD) will be requested to conduct a similar exam for 30 students who will be selected from the region. Each district will be given a quota of four students with Kassena-Nankana making up the remaining 10 spaces. Students will be bonded to stay and work in their respective districts for at least five years after completion before they will be eligible for transfer outside the district. They will also be required to work for three years before going for further training. The immediate concerns are outlined as follows:

1. Demonstrate a "Lead District" CHO training programme for a Regional Health Administration. At present, the CHPS initiative lacks a coherent model for developing service capacity in the 10 regions of the country. By developing a coordinated programme of CHO-certified training, the UER will demonstrate ways in which other "Lead Districts" in Ghana can develop health capacity.

2. Demonstrate an approach to health services that solves more general reproductive health needs. Youth employment now represents a growing crisis. In all, nearly three thousand secondary school students drop out in the region every year. Employment opportunities are often limited only to dressmaking and hairstyling. Social research has suggested that the lack of opportunities for girls may be an important factor in the rapid rise of sexually transmitted diseases, HIV/AIDS and early pregnancies among youth. Like the NHRC which now provides employment to some 400 youths in the district, the Community Health Training School will provide an occupation for at least 30 girls a year in the region.

3. Recruitment of students. Two options will be explored. i) Students from the UER who have passed the entrance exams but could not gain admission into the boarding schools could be recruited; ii) A special exam could be conducted by the HRD for candidates who have the required SSSCE grades before a selection interview.

4. Certification. Graduates of the school will take the same final examinations as students from the

established community health schools and thus go through the same process of certification by the Nurses and Midwives Council.

5. Absorption into the GHS. It is hoped that plans will be made to recruit graduates of the school into the GHS and be paid by the Ministry of Finance.

A CHN Training School in the KND will provide a constant stream of nurses for the Upper East Region, be a base for further developing the curricula for nurse training in the other schools, and motivate other regions to set up their own training facilities to support the national CHPS. When fully functional, the School will help in a substantial way to stem the tide of an estimated 500 teenage girls that leave the region every month to work in demeaning and unproductive roles as "Kayayooos" and maid servants in the southern parts of the country.

Long-term plan

1. Stage I. First, communities will be approached about the proposed programme, a site will be selected, and work will commence on a community-supported construction effort. (Paramount Chiefs of the District have expressed great interest in the underlying ideas of this proposal and one has offered to provide land.)

2. Stage II. In addition to running as a school, the site will be used as a dissemination and orientation facility for national health officials, Regional Health Administration, and DHMTs. This programme will orient visitors to the opportunity of developing "Lead District-based" CHO training facilities throughout Ghana. The well-drilled nurses who have had years of experience in the programme can be counterpart supervisors and consultants to the school, serving as village mentors to trainees assigned to work in the community as CHO interns.

3. Stage III. It is often difficult for many girls in the three Northern regions to obtain required grades that will qualify them to enter CHN Training Schools because of poorly resourced schools, poverty on the part of parents preventing them from investing in girls' education, and lack of role models. Sensitization, career guidance, and counseling will be vigorously carried out

in Junior and Senior Secondary Schools to encourage girls who are interested in community health nursing to work toward that goal.

Volume 2, Number 24, 2002

TWO BIRDS, ONE STONE¹

Navrongo: We have come here to tap your expertise for setting up a Day CHNs Training School in Navrongo. This is an attempt to find solutions to staffing challenges raised by the CHFP, which addressed questions about the impact of health interventions on child survival and family planning. After demonstrating that it works, Nkwanta District in the Volta Region addressed questions about transferability of the Navrongo model in resource-constrained environments. This culminated in the formulation of the CHPS which is now the government's policy for widening access to health care and a strategy for alleviating poverty. Over a third of districts across the country are now implementing a CHPS programme. While communities hail CHPS as an initiative tailored to their health needs, the health system still has not answered the question of how to raise the required number of staff for CHPS. It is now being seriously considered that for sustainable CHPS implementation, communities must be able to train their own nurses who would come back and serve their communities as CHOs.²

We are happy to inform you that the KND Health Management Team (DHMT) and the NHRC are

leading the way in starting a Day CHNs Training School in Navrongo. The School will use the same syllabi used in other community health training nurses schools and all efforts will be made to maintain the high standards associated with the training of nurses in Ghana. The Upper East Regional Director of Health Services, the MOH—particularly the HRD—are committed to seeing this idea become a reality.

Tamale: That is a laudable idea. Next step is to seek government commitment to support the project with both human and material resources.³

Navrongo: We are exploring a variety of sources to supplement what the government can provide. We have contacted some NGOs and the response is great. What are some of the obstacles in our way?

Tamale: One of the biggest problems is how to get qualified and committed tutors for the School. Students who enroll in the programme these days are so academically weak that it takes skilled and committed tutors to train them to become good nurses.

Navrongo: The Director of HRD has promised to support us; Navrongo has some expertise; a large pool exists of experienced, retired nurses in the Upper East Region who would benefit from finding themselves useful again. We have also contacted the University for Development Studies for assistance.

Tamale: Mobilizing local resources is essential to the sustainability of a programme like this.

Navrongo: What should we look out for in selecting students for the school?

Tamale: You need to know that students who are very intelligent may not necessarily be morally fit to train as nurses. With day students it will be difficult to supervise their assignments. Some of them have family problems to solve when they leave the classroom. This hampers their studies. There are financial implications in getting accommodation, securing academic materials, and food. All this can affect the student's academic work.

Navrongo: We are tackling the financial issues from a variety of angles. The KND Assembly sponsors students

¹ Highlights of a discussion between the Navrongo Health Research Centre (NHRC) and the Kassena-Nankana District Health Management Team (KND-DHMT), and the Tamale Community Health Nurses Training School (TCHNTS) on modalities for establishing a model Day Community Health Nurses Training School in Navrongo.

² The Navrongo team was made up of Ms. Rofina Asuru, PI, CHFP; Dr. Kweku Enos, District Director of Health Services, KND; and Santuah Niagia, Communication Specialist, CHFP.

³ The Tamale team comprised the Principal of the TCHNTS, Ms. Agatha Molbila; two Tutors, Ms. Juliet Atinga and Ms. Mercy Chimsi and, Ms. Hawa Amadu, Teaching Assistant.



The Navrongo Day School project aims to kill two birds with one stone: Training more nurses for door-to-door health delivery and finding jobs for school leavers

in training colleges to come back and serve the district. It should be possible for the Assembly to sponsor students to train in the Day Nurses Training School too and we are presently discussing this with them. We are also exploring the possibility of the NHRC offering part-time jobs to students so that they can earn something to buy books. We have big dreams but we are not overly ambitious. We are looking at killing two birds with one stone as we get nurses for our district we help the young girls find useful employment. We want to start with a small class of 20 students by September 2002.

Tamale: With the Research Centre to back you, you are already up to a good start.

Navrongo: How many subjects do you teach here?

Tamale: Formerly we taught Maternal and Child Health, Personal and Environmental Hygiene, Control of Communicable Diseases, First Aid, Community Health Aid, Nutrition and School Health. The Nurses and Midwives Council (NMC) have added Computer Training, Communication Skills, and Research Methods. Other additions include, Liberal Studies, African Studies, Mathematics, Statistics, and Pharmacology for which we have had to employ part-time tutors.

Navrongo: What are the essential things for a Demonstration Room?

Tamale: We use a list of items obtained from the NMC. You would need, among others, about 2 beds, admission bed, a crutch, a screen, a table, 2 chairs, some charts, the anatomy of a pregnant woman, a normal woman, a baby, and a placenta. You also need the Pelvic Chart or the whole of the anatomy on a chart, the structure of the teeth, the breast and the female pelvic, bed sheets, sandals etc. The visiting bags for each of these items are very important. Most of the items cannot be obtained in Ghana and may have to be imported from abroad.

Navrongo: I have seen some Ghanaian training models used by some NGOs. I think these can be very useful. How are your courses organised now? What about practical training?

Tamale: There are four semesters and the students have six weeks of practical attachment to district health directorates.

Navrongo: Thank you for the insight. This will guide us in establishing a day nurses training school in Navrongo.

Tamale: I assure you that you can make it. You have the commitment and all that it takes to succeed. Good luck!

Volume 2, Number 25, 2002

GIVE US THIS DAY OUR DAY SCHOOL

The Navrongo initiative

In the KND of the Upper East Region of Ghana, health for all has become a reality. CHNs have been retrained, equipped, and deployed to live in villages to provide door-to-door and compound-specific health care services to the rural poor. The questions raised in Cairo at the 1994 ICPD have been answered comprehensively in sixteen communities where community members have constructed "Level A" clinics known as Community Health Compounds (CHCs). These clinics, and a doorstep service delivery system that accompanies their construction improves access to quality and efficient health care. A system of community mobilization has been

developed to augment the community health programme with durbars, outreach to chiefs, mobilization of male and female social networks, and information directed to the needs of men. Taken together, the CHFP represents a model for community health care that can be replicated in districts throughout Ghana.

The need for a model CHO training component of the CHPS. In 1999, the national effort to scale up the Navrongo CHFP was instituted in a policy statement calling for a coordinated programme of translating static services into community-based health and family planning care based on the Navrongo model. To facilitate the process of operational change, a highly decentralized approach was instituted in which district teams would visit Navrongo for a training programme. Training would emphasize the process of pilot trial in other localities, and adaptation of the Navrongo system to local realities and needs. Priority in this programme was placed on starting work in 10 “lead districts” where unusual commitment to the initiative was manifest.

District teams have been trained in Navrongo in a counterpart model. In this approach, the DHMT, a sub-district supervisor, and one or two CHO are trained to start Navrongo-like operations in one or more sub-districts. When experience with this programme showed that CHO needed applied community-based training in community liaison, community-based service delivery, and special care to broaden their technical skills, a component of the Navrongo training programme was added to accommodate trainees from the four existing nurse training centres. However, since the training capacity of these centres is limited, any add-on module to their programme is, by definition, inadequate. There is a clear need to demonstrate a CHO training capability that includes the existing classroom curriculum and adds the Navrongo CHFP community counterpart orientation component.

The CHFP nurse staffing requirements. At various stages of the programme, the CHFP has seen an exodus of nurses for further training that continually threatens to destabilize the integrity of the research programme. At present, only 14 of the 16 study villages have resident CHO owing to regional staff shortages. The problem of



Even under the Community Health and Family Planning Project (CHFP), nurses for compound-specific health service are in short supply

CHO shortages will expand in 2003 when the CHFP plans to extend operations into communities that do not at present have resident nurses. The full complement of CHO required for the district by 2003 will be 33 nurses plus the 16 required for existing CHC. By addressing this shortage, Navrongo can lead the way in demonstrating a model for low-cost, sustainable, and replicable means of supplying communities with CHO. Existing abandoned structures will be used in a cost-effective development of a training centre for the Upper East Region.

Our day school

The KND is suitable for setting up a training school for the following reasons:

1. An ideal field site exists where theory is linked to practice. There are 16 retrained CHN who live in communities and offer doorstep services and compound-specific health education thus fulfilling the objective of training CHN.
2. The availability of human resources at the NHRC as well as the University for Development Studies for training.

3. The presence of modern facilities such as a computer centre, a reasonably equipped library, a video laboratory, and dissemination centre that can be used by students.
4. There are projects running at the Centre in which students can participate.

It is envisaged that the day school will eliminate the burden of hostel facilities, dining halls, and other structures that characterize all boarding schools. Students will commute every day from their homes to attend lectures. Field experiences will take place in health institutions including CHC.

While we will rely on the Human Resource Directorate to provide core staff, we will also draw on the NHRC and the region's abundant human resources for teaching purposes. Several individuals have completed graduate and diploma health programmes and are working in the District and region. The University for Development Studies has a campus in the District, which will also be a resource for the school.

The regional and District health, traditional, and political authorities are united behind the Day School initiative and are determined to see it succeed. The building formerly occupied by the MCH that has been earmarked to host the school and staff has already been relocated to the War Memorial Hospital in Navrongo. The structure is undergoing renovation to bring it to the required standard for use as both classroom and offices. A nine-member committee has been formed and charged with preliminary implementation work and is presently working in earnest towards the successful realization of the project.

Nature of training

Semester programmes will be run with emphasis on practical attachment to counterpart CHO. Host CHO will act as supervisors and consultants to trainee nurses in the communities so that student nurses are exposed to practical daily encounters and "learn by doing." CHO have been trained to treat minor ailments, give compound-specific talks, provide reproductive health services including emergency deliveries, expanded



Former maternal and child health building ready to receive the first 50 students of the model Day community health officer (CHO) training school

program on immunisation (EPI), referral, and mobilize communities for health action. Sub-district staff as well as DHMT and NHRC staff will also supervise students.

A portion of semester breaks will be spent both in the student's home region for further practical experience in maternity, MCH, FP services, and a portion with District CHO. In addition to core instructors and facilitators, tutors from existing schools in the region will be utilized for teaching various courses. Field experience will be conducted in all six districts at Health Centres to be identified by the DHMT. The regional hospital as well as the five District Hospitals will be used as field sites. Periodic exchange visits will be paid to the Tamale Nurses Training School.

The teaching methods will combine lectures, roleplay, demonstrations, discussions, case studies, and audiovisual aids such as documentaries. Teachers will be invited from other Community Health Nurses Training (CHNT) schools to offer assistance. Interim assessment will be done periodically and teachers from the traditional CHNT schools will moderate semester exam questions.

If the Navrongo Day CHNT makes it, and progress and enthusiasm so far suggest that it will, districts across the country will be drawing another lesson from the ongoing Navrongo CHFP whose seeds are already sprouting countrywide.

Volume 4, Number 13, 2004

COMMUNITIES LEADING COMMUNITIES

Where the national CHPS Initiative is making remarkable progress, DHMT move one step at a time—with communities leading other communities. Bawku West District has deployed only three CHOs but the results achieved so far surpass expectations—the use of family planning, for instance, has more than doubled in just one year!

This is how it all began

In 1999, the DHMT visited Navrongo to observe CHFP operations at the community level and interact with project staff about planning for CHPS. Upon return from Navrongo, the Bawku West DHMT moved into high gear. First, all district administrators and stakeholders were briefed on the CHPS process. In collaboration with the DA they selected Tanga zone—for reasons of its remoteness and dense population—to implement CHPS as a pilot project. The area also had dedicated opinion leaders ready to support the CHO and the residents themselves were committed to seeing the Navrongo innovation bear fruit on Tanga soil. A community-sensitization durbar was held to explain the new concepts and clarify the roles of the different actors such as the CHO and DHMT; the value of community participation, contributions of the DA, and input of the sub-district were also presented. The DHMT quickly refurbished an existing building that required little rehabilitation for use by the Nurse. Community-based health workers (e.g. TBAs) were active in Tanga; the community reorganized them and with the selection of a few more assembled a corps of health volunteers to work with the CHO. The chiefs, opinion leaders, and community members showed keen interest, pledged their support, and promised to work to the best of their abilities to make CHPS successful.

A nurse was selected and trained in Navrongo and deployed. The Regional Health directorate provided her with a motorbike and supplied bicycles for the health volunteers whilst the DHMT contributed gas lamps,

tape recorders, raincoats, stationery, drugs, furniture, and other logistics from the Donor Fund. But...things were too good to be true the nurse left for further studies and the programme came to a halt deeply damping the spirit of even ardent CHPS advocates. Still, perseverance took the better control of team members; in 2001, the district sent three CHNs to train at the NHRC. Meanwhile, volunteers continued to be active in Tanga and that kept CHPS alive until the next nurse was posted. The pieces of the puzzle were reassembled. Once success was steady, the team moved to the next community, Teshie, carrying along with them the formula for success from Tanga—communities owning the process and playing the leading role. Soon the DHMT extended services to Gogoo community far east, in fact far east enough for Gogoo to be easily mistaken for a community in Bawku East!

Commitment of the people, Chiefs and Elders, the presence of NGOs in the district—notably Action Aid—and the peace prevailing in the district have been singled out for special mention as having contributed in a significant way to the smooth implementation of CHPS in Bawku West. The DHMT Donor Fund also played a key role in getting programmes started and sustained.

All 15 steps of the CHPS process have been completed in all 14 of the district's zones and impact has been great. The innovative strategies employed improved access to basic health services and increased performance coverage but, above all, the strategies reinforced



Typical compound in one of Bawku West district's leading communities served by the resident nurse



At Gogoo community: Once a discussion is set in motion, the community health officer (CHO) sits back and takes notes from the men

community participation in discussing health issues. The community and health worker partnership has been strengthened. There has been increased programme coverage and an increase in the number of cases seen by the CHO such as ANC, Yellow Fever, Measles, Polio3, supervised deliveries, BCG, and PNC. From 2001 and 2002 BCG rose over 30% from 410 to 607 and growth monitoring increased by 30% from 2238 to 3175. Most remarkably, family planning acceptors have more than doubled from 224 to 500. Antenatal care rose by 18% (633 to 775) but supervised deliveries went up from 218 to 310, an increase of 30%—a much better performance than happened in Navrongo under experimental conditions.

Today 21,656 people representing 26% of the population receive regular CHO services. Two more nurses have been trained to operate at Zongoire and Tilli, the next two communities on the waiting list. Five down, nine to go!

Conclusion

First, Bawku West uses its own resources, both within the DHMT and the community to get started. They target resources so that they can be sure whatever is started is finished in a zone. That is, they do not start more zones than can be actually moved forward. Second, the district taps Navrongo's resources to make progress;

they used their connection with the NHRC to train four nurses. The district is sponsoring two students at the Navrongo CHNTS and plans to send three more nurses to train as CHO in 2003. But most importantly, they use communities to lead other communities. Once success is achieved in one community the experience is shared with another community—the successful community leads the way—serving as consultants and sources of ideas. All durbars in functioning zones are used to promote CHPS among communities not yet involved. This strategy of communities leading communities is a key innovation that merits emulation by other districts. This way CHPS will scale up gradually in tandem as new resources flow. As it were, Bawku West does not dwell on its difficulties; they just build on success!

Volume 3, Number 14, 2003

SAM'S SUMS

Dr. Samuel Kweku Enos has been District Director of Health Services of the Kassena-Nankana District for the better part of the life of the CHFP. He discusses his work.

How do you intend to scale up the CHPS across the entire district?

There is a plan to put up CHCs in all communities. In fact, this plan has been in existence for about three years



One of Bawku West district's 4-star community health officer (CHO) residences at Teshie community built with support from development partners

now and it is largely dependent on funds because a lot of money will be needed for its execution. Donors have pledged to support this plan but it must be noted that some of these donor funds come with their own problems. Some funding comes with designated contractors to build the CHC and this impedes community participation in the construction of the compounds. For this reason, we will suggest that funds designated for CHC construction are channeled through the DHMT which can team up with the communities to build their own CHC. This ensures community participation and ownership since community members are actively involved in the work including especially the location of the compound.

How does the DHMT collaborate with the DA in spreading CHPS?

Collaboration between the DHMT and the DA has been very cordial from the beginning of the initiative. The DA has been very supportive of the CHPS programme. But one problem we often encounter is the frequent reshuffle of Assemblymembers and District Chief Executives. Whenever these changes occur, we have to take pains to educate and sensitize the new occupants of these positions all over again and it has not been an easy task at all. Also, some of the new people may see things differently from the way we see them as health professionals.

What should be the focus of CHPS?

CHPS should focus on answering the question that the MOH and now GHS asked in 1997: *"How do we effectively deliver health services to the majority of our people especially those in the rural areas?"* The answer to the question is to send nurses into the communities to live with the people, learn from the people and provide services to the people to meet their needs. CHPS should aim at bringing this answer to reality. This has been proven in Navrongo to be the most effective way of delivering health services and it is what is being scaled up. It should focus on providing health care to the doorstep of the people.



The district health management team (DHMT) teams up with the District Assembly to get things done

Does CHPS help address financial hardships of clients?

In a way it does because if one has to travel a distance of about 16 kilometres to get to a health centre, transport costs are involved. So if we take the health services to the doorstep of people, they save money on transportation and that is a financial gain and the money thus saved can be put to other uses.

How healthy are KND's health indicators? In the KNDA?

Very impressive! Some workers from the Bill and Melinda Gates Foundation malaria institute visited the district sometime ago to look for nonimmunised children so that they could introduce a vaccine. Fortunately for us, but unfortunately for them, they found none. My basic statistics show that we have covered the whole child population in the district. For the past seven years, there has been cholera control in the district. Measles, which used to kill many children, has also been eradicated due to the efforts of our hardworking CHN and other health workers. Another indicator is that the KNDA was adjudged nationally as the best district in TB management. Notwithstanding these few impressive health indicators, we encounter problems. One of the most disturbing problems is the gap that exists between antenatal care and supervised delivery. Up to 80% of pregnant women report for antenatal services, but only about half of them turn up for supervised delivery at

health facilities. This is not good enough, and we are devising strategies to reverse this trend.

You have actually taken part in developing the *What works? What fails?* series, do you think we are achieving the purpose for which the series was developed?

The objectives set are being gradually addressed especially in the case of letting other districts know how far Navrongo has gone with CHPS and the particular techniques that helped to make the CHFP a success. But I have noticed that we are dealing more with the “what works?” whilst little or no attention is given to the other side the “what fails?”. I strongly recommend more notes on “what fails?” so that sister districts that want to implement CHPS will get to know the loopholes inherent in the process. It is also easily noticeable that notes on the results on the CHFP are lacking. The series must also dwell on the strategic processes of CHPS because these processes are not easy to comprehend. This technical information must be made available to other districts.

How does the DHMT and the NHRC collaborate for the implementation and dissemination of CHPS?

Nationally, the dissemination of CHPS has not been conferred on the NHRC. Initially, we thought that after the experiment was proclaimed successful, the DHMT and the NHRC would be given the nod to help in the dissemination but everything remained silent. Meanwhile in the beginning, we disseminated to the directors of the ministry and we also carried it to three national fora. In fact we tried but we haven't been given any specific roles to play in the dissemination.

How about the NHRC and the DHMT collaborating to internationalize CHPS?

Even though the NHRC and the DHMT have been involved in running the District Health Systems Operations (DISHOP) workshops, which trains DHMT and introduces others to CHPS, we should concentrate on promoting CHPS on the domestic front first. With time, the programme should sell itself to the outside world. Falling back on Navrongo to provide training will come as a matter of course.



Some of Kassena-Nankana's healthy indicators

Volume 3, Number 17, 2003

LEADING THE LEADERS

“If the followers agree to lead, the leaders will follow” is no longer just an adage Juabeso Bia district has proved that it's fact. Once a district where no health staff wanted to be exiled, Juabeso Bia has managed its operations so well that today health personnel are queuing up to be posted there.

For Juabeso Bia, CHPS progress has made the district an attractive place for health service work! But how did they get there? For starters, Juabeso Bia has sent its staff to other districts to learn about operations, and adapt innovation to local needs and realities. For example, 30 district staff have visited the NHRC the highest number of health personnel from any district to have visited the NHRC for CHPS orientation. The District Director of Health Services for Juabeso Bia, Dr. Jack Galley, contacted his friend, Dr. Abraham Victor Obeng Hodgson, the Director of the NHRC in Navrongo. He was invited to participate in a DISHOP, an In-Service Training Programme for Health Personnel across the country, in Navrongo in July 1999. On his return, he and his staff decided to start Navrongo-like operations in Juabeso Bia. Once the seed was planted—after consultations with Chiefs, Elders, and Assembly members—Juabeso Bia has not looked back since. The DHMT proceeded to visit other districts, even after they started CHPS. The entire team also visited Nkwanta in 2002. Seeking togetherness with others is the *zurugelu*



Following the leaders so as to lead the followers

approach to getting things done. Juabeso Bia has put everyone in the picture from start to finish, but mainly from the start!

Juabeso Bia is a large Western Region district—both in surface area and population. It stretches from north to south for 150km and has a 2000 census population of 242,119. The district is bounded to the west by La Cote d'Ivoire, to the south by Sefwi Wiawso, to the north by Dorma, to the north-east by Asunafo, and to the south by Aowin Suaman.

Big things begin small

The problems for CHPS to address in the district were daunting. As of 1994–95 Juabeso Bia had only six MOH health delivery points in only three out of the six sub-districts. But the district was blessed (or some would say cursed), with many scattered private clinics and maternity homes. The main referral points were Sefwi Asafo, Dorma, Berekum, Sunyani, and Komfo Anokye—all over five hours drive away for the lucky few who could afford transportation. By December 1999, there were only two State Registered Nurses (SRN), one SRN Midwife, two Enrolled Nurse Midwives, one Senior Medical Officer, one Senior Nursing Officer, (General), one Public Health Nurse, and one Nursing Officer (PH) in the entire District. The rest of the staff were either CHNs or Enrolled Nurses.

Staff shortages were only the beginning of the challenge. The district was plagued with numerous

health problems which were compounded by several inaccessible communities due to poor road networks and tough terrain. The district was reporting the highest number of communicable and childhood diseases such as measles and malaria in the region. Services were not reaching the majority of the people, and the limited number of health services with an inadequate health infrastructure resulted in high maternal and infant morbidity.

There was therefore an urgent need to upgrade the Juabeso Health Post into a district referral health centre that will eventually become the District Hospital.

Foreseen problems

Staff understanding of the CHPS concept was poor and motivation for implementing it was predictably low. Private practitioners had every reason to resent competition with the CHO whose services were soon to be readily accessible, more efficient and affordable to the people. Financial support for moving forward was a nagging pain in the neck. But Juabeso drew inspiration from the fact that no matter the odds health could not wait.

What works?

Before anyone thought about CHPS, private nurse practitioners were already effectively deployed throughout the district providing compound-specific health care. Instead of seeing them as competitors in the delivery of health care, the DHMT took them onboard as partners—training and legitimising their work—much to the consternation of unqualified practitioners and quacks. All manner of skilled personnel available were slated for training. Both regular staff of the DHMT and private medical practitioners were invited to be part of the teams that visited Navrongo to receive counterpart training. The biggest advantage of using private practitioners is the potential for improving service quality with low investment. Sustainability is also guaranteed because there is very little or no attrition of health workers. Moreover, ignoring private service providers is tantamount to creating a competitive rather than a cooperative climate for CHPS development.



Juabeso Bia team members learn by doing

Juabeso Bia has also been innovative in its use of health volunteers. Unlike in Navrongo where volunteers are trained in the “Bamako Initiative” approach for administering basic drugs and contraceptives as well as treating minor ailments, Juabeso Bia has restricted the work of the volunteers to health mobilisation—assisting nurses in organizing vaccination coverage (NIDS) and distribution of Avermentin, NMT, and CBS. They are also used in defaulter tracing for DOTS and EPI. But above all, volunteers in Juabeso Bia are social mobilisers for health and family planning—community animators and CHO backstoppers who involve men in social support for reproductive and child health.

The district has also relied extensively on identifying and efficiently managing resources within the DHMT. To build morale and support for the programme, CHO are provided with a television set and cooking utensils as they leave for community postings. Monthly meetings are also organized to exchange ideas and discuss ways of handling challenges encountered in the field. For the future, Juabeso Bia is looking at the role of CHOs in the Community Health Insurance Scheme, CHOs and HIV/AIDS especially people living with the disease (PLWHA), strengthening the referral system with radio telephones, and improving the district's data capturing system.

Have these innovations worked?

First, take a look at the PPME maps of Ghana: Juabeso Bia has achieved more coverage of doorstep care than any



Comparing notes on site to guide others

other district in Ghana. Obviously, Navrongo counterpart training has left its footprints on the health chart of Juabeso Bia. After the sensitisation visit, staff became enthusiastic and moved to their own chosen stations. Now services are reaching larger numbers of people than ever before. Communities have started showing open appreciation for the efforts of the DHMT—especially in the pilot areas. Health services coverage has increased and the most remarkable achievement is that maternal mortality tumbled by 37% in 2002. Staff willingly accept posting to Juabeso Bia and the district is now advancing the concept of CHPS in the Western Region. The CHN in the pilot areas are particularly happy with their work, as their roles have now changed to that of multipurpose health worker. But Juabeso Bia has to keep trotting just to keep still, and if it must advance then it must keep running. The most refreshing of their future plans is the goal to complete more study tours! Not only is the district the leader of leaders, it is still seeking ways to learn from others.

Volume 3, Number 21, 2003

DOUBLE TROUBLE

The Ga district is taking Navrongo to new heights it is leading the way in experimenting with implementing the CHPS in urban settings. Essentially a strategy for

reaching rural areas with affordable health service, CHPS seems to have successfully migrated to the city and doing just fine. Generally, urban centres are better endowed with health services and facilities than rural areas. The Ga district is disadvantaged by its deceptive closeness to the capital city. It is very urban and very rural at the same time, and that is double trouble for a district that could easily have been a region on its own.

The Ga district has 625,000 people who live in mostly small settlements numbering about 500. There is poor geographical access in remote rural areas and limited access for peri-urban fringe squatters. The population is fluid and constantly on the move. The Ga district is not only a crucible of many cultures; it is also described as the “melting pot of diseases” in Ghana. Before 1997—long before CHPS became national policy—discussions had been held with the Ga District Assembly (GDA) to extend health services to all parts of the huge district. The idea then was to build “Health Stations” the equivalent of CHCs where health staff would live and provide services to the communities.

Implementation milestones

CHPS started in 1999/2000 with initial planning, stakeholder sensitisation, and community mobilization. In collaboration with the GDA, 29 rural zones were demarcated for CHPS in August 2000. In November, the first big stakeholder consensus-building and planning meeting for district health development was held and supervisors were subsequently selected. This supervisory staff was made up of a Public Health Nurse, a Senior Nursing Officer, and a Nursing Officer. At the beginning of 2001 a CHN Midwife, a CHN, and an Enrolled Nurse were selected to be CHOs and taken through initial orientation and training sessions. The rest of the year was dedicated to more intensive work in communities, mobilization, and negotiations with stakeholders such as Rotary and communities—notably the Kwashikumaman Unit.

By the end of the year, support had been secured from the Social Investment Fund for constructing CHCs. This was followed by procurement of motorcycles and other logistics needed for deploying

the nurse. During the first quarter of 2002, land for the CHC and training in motorbike riding was launched. Social Investment Funding was secured for a CHC at Nsakina. A package in the form of additional duty hours (ADHA) was institutionalised as incentive for CHO and supervisors. In the second quarter of 2002 the first CHO grand durbar was held at Nsakina. Selection of volunteers and formation of Health Committees was carried out in the third quarter of 2002 with the involvement of Assembly Members and Unit Committees. By the end of the year, volunteers underwent training. During the first quarter of 2003, the Ga District Assembly constructed a CHC.

Challenges

Like many districts implementing CHPS, Ga district was up against the usual challenges of inadequate logistics, staff, and funding. Coupled with this was the realization that access to health care in an urban setting had to do with barriers other than geographic—the populations were poor and marginalized. There were inadequate safeguards for motorbike riders who were in danger of being run over by vehicles. CHO were unwilling to take those risks. However one of its toughest and peculiar challenges was that the local political authority insisted on the construction of clinics for the communities, not just CHC. The situation was not helped by an errant

“When you have more than good reasons to stop doing something, innovate.”



Dr. Ernestina Mensah-Quainoo, District Director of Health Services, Ga District Health Directorate

CHO who blatantly indulged in malpractice and whose actions and behaviour caused dissention among the community. The situation was compounded by the lack of any form of local government when CHPS activity was launched in 2001.

There is a critical need to bridge health inequity between rural and urban locations. The fact that the Ga district is an urban setting sets the stage for innovating the implementation of CHPS. CHPS in an urban setting poses peculiar challenges. In rural areas the population is fairly stable; in urban centres the populations are mixed and there is a constant influx of people. There is no traditional society in the real sense of the word and family ties are nonexistent or at best very weak. In the Ga district, there exists the unreached, marginalized, and vulnerable urban poor whose plight is worsened by the existence of social barriers that limit access to services. The communities and populations are hard to define. There are permanent but marginalized urban poor with no house addresses. There is a large drifting squatter population in the fringes as urbanization advances. There is no recognized leadership or power structure, such as Chiefs, Elders, or opinion leaders and contact persons. This makes community entry and mobilization difficult, if not altogether impossible. In urban settings such as Ga district, land is not readily available; it is already built up, sold out, or too expensive. There are no community natural resources; no organized procedures for raising funds. Communal spirit is very low. It is therefore difficult to build consensus for a CHC.

Innovation

In the midst of these daunting challenges the Ga district had more than good reasons to say CHPS would not work for them. But according to the Ga District Director of Health Services (DDHS), Dr. Ernestina Mensah-Quainoo, “*when you have more than good reasons to stop doing something, innovate,*” and that is what she did. In rural areas such as Kassenan-Nankana, a population is much easier to define. People may be identified as belonging together because they have a common ancestor, draw water from the same stream, attend the same funerals, observe the same taboos,

worship at the same shrine, are separated from others by a river or a hill, and share a common vision and destiny. But in the urban setting, defining a population is almost as difficult as sorting ancestors out by their fertility preferences. For the purpose of zoning out for CHPS, the Ga district has set criteria for defining its population:

1. Common interest or association: People who know each another, congregation families (members of the same church or mosque); resident associations; Market Trader Associations/Businessmen families, and basic school families.
2. Registration based on information disseminated through: FM radios, places of worship, funerals, and markets.

Registration is done in concentric circles around a CHC until the required population figure is attained—yet it is not as easy as that. Often service delivery has to be provided in order to enhance registration. Acquiring land for CHC construction is another major headache since all land has been allocated, built up, or is expensive. Often the only available public lands belong to academic institutions, religious bodies, and the DA—or is earmarked for markets or recreational facilities. Taking land from other public sector institutions such as the police, has always remained a viable option. Several options remain open with regard to acquiring a CHC. The nurse may be required to use his/her live-in



Dr. Ernestina receiving three of her community health officers (CHOs)

quarters. A facility may also be rented, and with the landlord's permission, an additional structure added.

Impact

Within these constraints, the Ga DHMT has succeeded in establishing the health system's presence at the community level with real community appreciation. Disease surveillance and early epidemic detection is assured. There has been a generally upward trend in volume of curative and preventive coverage.

Recommendations

While appealing for specific support to develop CHPS in urban settings, Ga district recommends advocacy for CHPS through continuous sensitisation at both national and regional levels. Examples of these efforts are collaborations built with the Ministry of Local Government and Rural Development; and with the National Road Safety campaign for motorcycle riders to be provided reflector-labelled uniforms with specific slogans such as, *"I Ride for Health. Spare my Life!"* The DDHS says the district is eagerly awaiting support to tour other CHPS areas to learn what others are doing.

Volume 2, Number 26, 2002

DISTRICT 88888 CALLING!

After the Navrongo CHFP proved that it was practical and beneficial to deploy CHNs to live and provide doorstep health care in rural Ghana, concerns were raised over the practicality of scaling up Navrongo nationally. Now over 30 districts throughout the country are organizing health care delivery using the Navrongo model. Even outside experimental conditions, some districts have achieved results worthy of emulation, especially by Navrongo standards. One district which has shown great promise in the implementation of CHPS is Sene in Brong Ahafo Region. Created in 1989, Sene is one of the youngest of the region's 13 districts and is the largest district in the region—covering a land area of 8,586 sq km—five times the size of Kassena-Nankana

District. Located in the eastern part of the region, 3500 sq km of Sene District's total land surface is made up of islands. With Kwame Danso as its administrative capital, Sene shares common boundaries with Atebubu to the west, the Volta Lake to the north and east, the Digya National Park of the Afram Plains and the Sekyere East District of the Ashanti Region to the south.

The vegetation is mainly of the savanna type, with traces of the deciduous forest in some areas. The district has two main seasons—rainy and dry. Farming is the main activity employing about 75 percent of the population and produces food crops such as tubers, legumes, cereals, and miscellaneous vegetables; yams and groundnuts are the main cash crops.

According to projected figures from the 2000 Population and Housing Census, Sene District has a population of 87,058, however, the District Health Administration, which likely has a more detailed account of the population by virtue of the depth of its activities, puts the figure at 88,888! The District Director says outreach suggests the actual population may be in the hundred thousands since new villages are discovered every year.

There are four traditional Councils in the programme area, each with a Paramount Chief and comprised of the indigenous ethnic groups Dwan, Wiase, Bassa, and Nkomi, respectively. Other ethnic settler groups, which can be found in the district, are Dagarbas, Dagombas, Kokombas, Bators, and Asangbes.



Sene District, where inspiring figures on paper match facts on the ground

There are a number of religious groups dominated by the Seventh Day Adventist and the Muslim sects.

The communication infrastructure in the district is rudimentary. Only the main road from Atebubu to Kojokrom is accessible year-round—all other roads are simply tractor tracks made by tractors leading to/from farm settlements to transport produce. There is also a 17 km feeder road from the centre of Kwame Danso to Akyeremade Bator, a community on the bank of the Sene river. However, all these roads are rendered impassable during the rainy season, making accessibility to most of the communities impossible.

The only communication links with the outside world are the Post Office and two telephone installations in the district capital. There is a communication centre for the DA and one for the MOH. The district has been divided into four subdistricts for MOH activities. These subdistricts are Kwame Danso, Bantama, Bassa, and Kojokrom. The only Government Health facilities in these four subdistricts are Kwame Danso Health Centre, and Bassa, Kajaji and Kojokrom Rural Clinics. In addition to these are two private clinics—Sunta and Nya Kkwa Clinics. There is one private midwifery facility that does not function regularly. The four Government Health facilities have a total staff of 32, including three Field Technicians for disease control, one Technical Officer for community health, and five CHNs.

CHPS organization

The two selected zones for CHPS implementation are Bantama and Kyeamekrom. Bantama is located 8 km west of the district capital, while Kyeamekrom lies 20 km east. Bantama has 11 communities, which include Bantama Lailia, Wiase, Shafa, Dogondagyi, Maframa, Gruma Akura, Chense Bator, Adu Kofi, Nyanda, and Konkomba Akura. Kyeamekrom has a population of 8157 over a land area of 287 sq km. The zone is made up of 19 communities: Kyeamekrom, Atta Akura, Apaaso, Chaboba, Tendam, Kulungugu, Dagomba Akura, Kofi Gyan, Kwaku Donkor, Kwabena Kuma Akura, Bangyi, Sergeant Major, Agege Line, Kapacha Akura, Tato Bator, Dagarti/Kokomba Akura, Donkope and Kakraka Akura, and Ghamakpe.

The main economic activities for both zones are farming, fishing, and petty trading. Both zones are governed by subchiefs popularly called “Odikro.” They are assisted by ethnic group leaders, Assembly members and Unit Committee members. Kyeamekrom has an Area Council.

The two areas designated for CHPS have no health facilities. The District Health Administration has detailed one CHN to take charge of the Bantama zone. She moves into the community during immunization sessions and conducts child welfare clinics but has no accommodation within the community. Staff from the disease control and MCH units in Kwame Danso go into the various communities in the Kyeamekrom zone to conduct immunization and child welfare clinics.

Some of the major health problems identified in the two zones include Malaria, diarrhoea, hernia, Onchocerciasis, convulsion, pregnancy-related problems (e.g. anemia, eclampsia). Since there are no health facilities in these areas, people rely on chemical sellers, drug peddlers (quack doctors), and the use of local herbs in treating or managing these ailments. These problems contribute to high morbidity and mortality and also affect food production and eventually productivity and the standard of living. Though the disease burden is spread across all ages and both sexes, records show that woman and children bear the brunt of unsatisfactory medical care.

The idea of sending a CHO into these communities has been welcome news. The chief of one of the CHPS



Chief of Kyeamekrom announcing that a site for a permanent community health compound (CHC) has been secured for the Community health officer (CHO)

zones has pledged that when a nurse is sent to their community they would make her safety and comfort their priority. The community would provide the nurse with foodstuffs. The chief cited the example of how they treated a German volunteer in the past *"We would support the CHO much the same way as we supported the German volunteer and even do more,"* assured the Chief of Kyeamekrom, Nana Paul Mensah, at his humble Palace before his Assemblyman, Mathew Addae and the Youth Leader of the town, Kofi Fofie.

The people anticipate that with the relocation of the resident nurse, doorstep health delivery will improve health indicators, which, given the particularly difficult circumstances under which the DHMT works, is a lot to call home about.

Volume 2, Number 27, 2002

HEALTH BY THE BOATLOAD

The shortage of CHOs is one of the most serious obstacles in developing the CHPS. Even if all available CHNs were trained and equipped to provide community services, only a third of Ghana would be covered. Sene District in Brong Ahafo District has developed innovative solutions to this problem.

Listed as one of the poorest districts in Ghana as far as health infrastructure is concerned, Sene District has a heavy disease burden. From outpatient records of the District Health Centre, the top ten causes of ill health are all preventable infectious diseases, accounting for 97 percent of all outpatient cases. The malnutrition rate in the district is 18% and the major diseases are malaria, Acute Respiratory Infection and diarrhoeal diseases.

The settlement pattern in the district is highly dispersed, owing to successive generations of migration of new households seeking farmland. Health services are inaccessible to most residents. Roads linking communities to each other and communities to health facilities are poor, resulting in inequitable distribution of health services. Traditional health planning did not promote community participation in the identification,

planning and implementation of solutions to health problems. There was limited interaction between community residents and the few health workers in the district. Therefore the DHMT assumed that the successful introduction of the CHPS strategy would go a long way to solve this problem.

Twenty-three communities live on water making accessibility possible only by boat. The 'boat people' are constantly on the move in search of new fish breeding grounds and health personnel also have to keep moving in search of the boat people. Unfortunately the district has no boat to facilitate movement for outreach care. The district has often had to rely on the benevolence of other districts nearby such as Krachi district—which has some of its communities on water—to perform outreach. The district has therefore devised a camping strategy as an outreach method. During camping, all health personnel move to one part of the district and spend between four days to one week providing health services, then they move camp to another part of the district until the entire district is covered. This innovative CHPS approach demonstrates a core principle of the initiative: CHPS works when strategies are adapted to local realities and needs.

With regard to the *zurugelu* approach to health service delivery, the Sene District Health Administration, the DA and the community are collaborating very well, especially with regard to the construction of CHCs as dwelling places for nurses to facilitate doorstep health care provision. The District Director of Health Services (DDHS) has committed part of his quarterly budgetary allocation to CHC construction. Wood is acquired from timber felled in the community. Navrongo has already established the fact that farm work gets in the way of CHC construction, and this activity should be taken up seriously during the dry season. The CHC springing up in Sene are estimated to cost about €30 million apiece, just under US\$5,000.

CHC construction can always wait till the appropriate time but health cannot wait. To get things going, an opinion leader in Kyeamekrom, Mr. Kofi Nimwie offered part of his son's residence as temporary living quarters for the CHO while her permanent



With two new community health compounds (CHCs) in the offing, Dr. Rapheal Dakurah Dagoe can look forward to improving upon his impressive records

residence is under construction. The temporary accommodation has two gates so it has been agreed that each occupant is to use one gate. The District Public Health Nurse, Ms. Winnie Tiennah, says this arrangement is absolutely necessary since patients, especially family planning clients, require a respectable amount of privacy when consulting. Sene district grapples with limited and ill-motivated health personnel. There are 32 health workers in the whole district with one sub-district not having a health worker at all. The district needs a minimum of 20 CHNs but so far only five are available.

In spite of these limitations and trying circumstances, the *What works?* team was surprised to learn that Sene district has consistently won the best District Health Administration Award in the Brong-Ahafo region. It won the maiden award in 1996, then again in 1997 and in 1998. Since 1998 no award has been given but Dr. Raphael Dakurah Dagoe is optimistic that he is certain that the district will always emerge on top.

These successes have not been etched on a silver platter, however; the health seeking behaviour of the people continues to be lax:

“CHPS is good for the people [of Sene district] because they are apathetic about seeking medical attention they seem to be more particular about

their fishing and farm work than about their health. This is the more reason why we have to take the services to their doorstep or as it were, their ‘boatstep!’” says Dr. Dagoe.

How does this DHMT achieve success, despite all odds?

1. *Ownership.* Prior to CHPS, there was no sense of community ownership. By developing community dialogue and contribution to the program, full partnership has been developed between the DHMT and communities served.
2. *District-level CHO recruitment and training.* The most viable and sustainable approach to solving Sene’s health problems is to train local-level, community-selected nurses and build new CHC where nurses can reside and work. The DA and World Vision are committed to sponsoring persons to train as CHNs and come back to serve in the community. The regional health administration has been prevailed upon to admit students from Sene district to train as nurses after which they would be bonded for at least three years to remain in the community to provide services. As part of overall strategies, the regional health administration seeks to ensure that all nurses that go on study leave from the district come back after upgraded training. But the main problem is the severe shortage of CHO. The DDHS says the situation is so serious and he is so desperate for a quick solution that he is prepared to send students to train in the Day Community Nurses Training School being established in Navrongo.
3. *Improved referral.* With CHPS fully operational, hard-to-reach communities receive basic health services, such as health education and immunization. Nursing services are designed to facilitate quick identification and early referral of serious conditions.

Better coverage through mobile and resident CHO services, increased numbers of CHO, and improved referral care are expected to eventually reduce infant and child morbidity and mortality and lessen the overall disease burden of the district.

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THIS IS OUR CHPS

Nkoranza district of the Brong-Ahafo region lies in the transition between the rain forest and the savanna regions of Ghana. The district harbours some of the country's most fertile soil. Ninety-five percent of the people are farmers, which largely explains why the district is the leading producer of maize in Ghana. Other cash crops of commercial value include yam, cassava, groundnuts, and beans. Projected from the 2000 census, Nkoranza has a population of 134,236 spread over 1200 square kilometres. The inhabitants are heterogeneous—a mixture of Akan and people from other parts of the country especially northern Ghana. The road network is undeveloped, rendering most parts of the hinterlands inaccessible especially during the rainy season. There are 191 communities in the district with 18 functional community clinics.

The district is bounded to the north by Kintampo, to the south by Offinso, Techiman to the west, and Atebubu to the east. Nkoranza is one of the few districts to have visited Navrongo to acquaint themselves with the CHFP service-delivery strategy. By the time a Navrongo team visited to study progress of CHPS implementation, a few of the lessons had been brought to bear on the process. The Nkoranza District Chief Executive, Mr. Twumasi Ampofo, acknowledged the DA's valuable role in the CHPS implementation process and pledged his support to the DHMT, especially with respect to the construction of CHCs.

The District Director of Health Services (DDHS), Mr. Amofa Boateng, said lessons from Navrongo have been well learned but some modifications have had to be made to the CHPS implementation process in their district given the entirely different context. Two sub-districts, Ahiayem and Donkro Nkwanta, have been selected and zones identified for CHPS. One CHO has been put in charge of one zone in Ahiayem and one CHO for two zones in Donkro Nkwanta. Eighteen volunteers have also been selected and accounts opened for them at the bank to deposit drug money after sales. Stock registers have been opened for the health committee

to monitor the flow of drugs. The two CHO-designates have already been deployed to provide service and supervise volunteers. Though both volunteers and CHO have been selected, neither group has yet to be trained. The settlement pattern is comprised of many small, scattered communities which are best served by having the CHO remain resident at Level B clinics where they ride into communities to provide health care. Procuring equipment for commuting from one village to another is the major problem confronting the effective work of the volunteers in decentralizing access to health care.

At Ahiayem, about 30 kilometres southeast of the district capital, Ms. Agnes Adisa Amoah, the Nursing Officer in charge of the Rural Clinic, and the CHO-designate, Mr. Liptin Deyir Jacob, serve eight communities with a total population of 6,187. Mr. Liptin lives in a renovated structure formerly built by the community for use as a rural clinic before a new one was built. As a Disease Control Officer focused on preventive services, his lack of training in curative care is complemented by the nurse's background. The two of them go out on compound visits together. As she offers treatment for minor ailments, he concentrates on MCH and FP services. Disease control officers have not been identified as core CHPS workers, but this example indicates that this is an oversight. He plays a key role in coordinating the volunteer program. An issue that



Navrongo team holds discussion with a designated community health officer (CHO)



A former rural clinic building converted into a community health officer (CHO) dwelling place

remains unresolved is how the CHO's motorbike is to be fueled.

What fails?

- *Getting CHPS implementation out of order.* Nkoranza demonstrates an axiom of CHPS failure: Community health care fails when the service-delivery cart is placed before the community-entry horse. This axiom is particularly evident when health volunteers are deployed in the communities ahead of CHO deployment.
- *Community involvement in volunteer supervision.* But even where community entry is pursued, the volunteer program has encountered serious problems suggesting that DHMT should be cautious about volunteer deployment. For myriad reasons, some volunteers did not appear when their services were to begin. For volunteers that have actually started services, supervision has been problematic, particularly in communities where the leadership structure is not clearly defined or where there is no recognised chief. Without a clearly defined role for the community in supervision, volunteers become drug peddlers rather than health workers participating in the CHPS program.
- *Educating the community on volunteer roles.* It is important to educate communities about what services volunteers *should* not provide (such as treatment of childhood febrile illness). A well-managed referral system requires community understanding about the referral system and the

relative roles of CHO, sub-district clinics, and volunteers.

- *The need for volunteer training and supervision.* A well-established system for managing drugs and monitoring drug flow is needed as health volunteers can overstep their bounds—dispensing drugs and advice that may do more harm than good. If supervision is weak, health volunteers may divert parents from effective clinical services to volunteer-provided care for illnesses that volunteer-provided drugs cannot cure or treat. The volunteer system may be overtaking the CHPS initiative and there is the risk that without strict supervision volunteers would again assume the part of the dysfunctional “village doctor,” the drug peddling role of Village Health Workers in the 1970s. Volunteers have been provided with notebooks for keeping records and instructed to submit them regularly for inspection, but these rules are not always respected. Under such circumstances, deploying volunteers may do more harm than good.

What works?

One of the essential components of CHPS is for the nurse to relocate to the community and live among the people—and not remain at static level B clinics. In Nkoranza the concept seems to have been well implemented but modifications have become necessary due to their peculiar circumstances—particularly with



Traditional birth attendants at refresher training at St. Theresa's Hospital

regard to terrain and settlement. What works is to adapt the Navrongo service delivery approach to local conditions and not implement a carbon copy of what was done under experimental conditions. All volunteers have been provided with notebooks to register new births. This is a laudable idea which when properly implemented will serve as the basis for establishing an efficient management information system for the communities.

The District's health system is supported by a strong network of Traditional Birth Attendants (TBA). Out of 131 TBA, 105 are active. A Safe Motherhood NGO which aims to reduce infant and maternal mortality supports the TBA. It provides training, service delivery kits, and offers motivational packages to sustain TBA interest. All TBA undergo refresher training, and are supported by ambulance and radio communication systems which are provided for all sub-districts. Navrongo suggested that TBA, who are mostly illiterate, be taken through literacy and numeracy classes to enable them not only attain functional literacy but also to boost their prestige.

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WHO'S PUTTING SUCCESS TO WORK?

After results of the Navrongo CHFP were disseminated demonstrating the feasibility of reorienting health care at the periphery, the experiences and lessons of the experiment reinforced the MOH's commitment towards community-based health service delivery through the replication and adaptation of innovative approaches. All key policymakers were in favour of replication and expansion of the Navrongo experience but critical concerns were raised over the practicality of scaling up Navrongo nationally. Nkwanta district in the Volta Region took up the challenge and successfully replicated the CHFP thereby demonstrating, quite convincingly, that utilization of the experiment, with local resources, was feasible in other districts of the country. At the first

consultative conference in September 1998, to discuss the Navrongo community health strategy, Nkwanta District shared its experiences in replicating Navrongo and showed the way forward in reorienting health care delivery at the periphery.

By the next National Dissemination Forum in October 1999 the various directorates of the Ministry had agreed that the effort to coordinate the replication of Navrongo countrywide would be known CHPS.

But who's interested in history?

Nkwanta was not just the first district to replicate Navrongo. Some say its achievements go beyond mere replication. Nkwanta has been an innovator in CHPS service strategies since 1998. By the end of 2004, it will complete the implementation of CHPS in 18 zones, covering the entire district population. How did Nkwanta achieve this?

Nkwanta is the Volta region's largest and most deprived district. Its residents, numbering over 187,000, are spread over 5,500 square kilometres, more than three times the size of Kassena-Nankana District which has an equally large population. It lacks adequate medical coverage and its inhabitants suffer a high rate of communicable and childhood diseases. Maternal and infant morbidity and mortality levels are high. Residents have no access to potable water, endure poor transport and communication facilities; its laterite track route is impassable at the height of the rainy season, depriving



Dr. John Koku Awoonor-Williams dared to subject experimental findings to a rigorous test



CHO Margaret Asemsro providing door-to-door family planning counselling

many villages access to crucial health care. And as if woes never come singly, the vast district is served by a single physician. Faced with a multi-faceted challenge under the circumstances, the DHMT sought innovative and sustainable solutions by putting success to work. This approach follows very basic principles that all districts can also use.

- *Staff leadership and consensus.* The District Director, Dr. John Koku Awoonor-Williams visited Navrongo as early as 1998. While he learned about Navrongo in a personal way, he did not stop there. He developed team leadership for CHPS: the DHMT was familiarized with CHPS and came to Navrongo to see the programme in action. Dr. Awoonor-Williams just kept coming till he got it right. Then, supervisors were trained in CHPS leadership. Once the supervisory staff was trained, there was a focus on identifying two CHO who could be peer leaders of other CHO by making the programme work in a zone that could be a practical training ground for other CHO.
- *Community leadership.* Once a leadership team was developed, community leadership was nurtured, first through outreach to chiefs, elders, and community

leaders the crucial “community entry stage of CHPS.” But, the Nkwanta team did not stop at community entry. They focused attention on getting CHPS started in two zones—concentrating on practical issues of getting existing community resources mobilised for CHPS. Rather than waiting for external resources, the team focused on building a demonstration of CHPS that used local resources. Once a community made the decision to start CHPS, services were started even in the absence of equipment, facilities, or resources to supplement budgets.

- *Putting success to work.* In Nkwanta, success is used to generate success. Communities promote CHPS by showing CHPS’ success to other communities. There was no external assistance—just good evidence to guide the development strategies and a programme for communities that were making progress.¹ The Navrongo approach was changed in response to lessons learned. For example, the chieftaincy system in Nkwanta is diffuse, owing to the many ethno-linguistic groups in the locality, and the fact that as many as five chiefs might have crucial roles in a given community. To build cohesive community leadership, the Nkwanta team has had to work more closely with secular leaders, grass-roots politicians, and faith-based groups than was the case in Navrongo. Also, certain diseases, like guinea



The Community-based Health Planning and Services Initiative (CHPS) does not cost—it pays. Dr. Koku out in the field with his team putting success to work

¹ *What works? What fails?* readers can get the Nkwanta story in detail in the new series *Putting Success to Work*. It is available on the PPME CD ROM that is circulated to DHMT every 90 days. All issues are available by clicking the “Nkwanta” button on the opening display.

worm are major problems in the locality, requiring special training for CHO, and attention within community mobilization work. While the leadership team was oriented to CHPS in Navrongo, most of the training took place in communities where CHPS was working, and most community action was generated by having communities lead other communities.

This model of action-through-doing is a model for CHPS that involves “putting success to work.”

Koku is ubiquitous across the district. But he is not the only person involved in the philosophy of putting success to work. Other members of his team include: Issaka Adamu, Field Supervisor and Community Mobiliser; Stella Anku, CHPS Coordinator; Gifty Sunu, District Public Health Nurse; Pamela Quaye, Field Supervisor & EPI Coordinator; and Nutifafa Glover, Research Coordinator.

When asked how much it costs Nkwanta to roll out CHPS, Koku retorts, “CHPS doesn’t cost—it pays!”

Volume 4, Number 17, 2004

WHERE THE CHPS FALL...

Dr. Frank Nyonator is Director of the Policy, Planning, Monitoring and Evaluation Division (PPME) of the GHS. He has direct responsibility for coordinating the implementation of CHPS, a nationwide health care delivery initiative based on findings from the Navrongo CHFP. He discusses his work.

Generally, what has been the health system’s response to CHPS?

I would say, great. When the Navrongo findings came out the health system immediately recognized that this was a key strategy for addressing an age-old problem of poor access to health care for rural communities. CHPS has been recognised as a pro-poor strategy for addressing health equity issues and this has resonated through the health system. That probably explains why as a national policy we seem to be pushing it too hard.

The Northern region has organised a conference to assess the state of CHPS implementation. Is that your idea of the way forward?

Admittedly so. CHPS is a district-level issue that needs support and guidance from the regional level and that is what the northern region is doing. There is the need for continuous dialogue among the districts in every region aided by the regional directorate. This enables skills and innovations to be shared and best practices adopted. The region also gets to know the hot spots and if there is the need to shift focus and or resources to make things move, this is quickly arranged.

What is the strategy for helping the “laggards” in the CHPS process?

The CHPS M&E results indicate that 106 districts report that they have started CHPS. But for us we talk of completed CHPS zones. It is only a completed zone which can start delivering services because it will have gone through all the steps. Currently there are only 48 completed CHPS zones. Over 1,096 zones have been demarcated and are at various stages of getting started. We have observed that when a district completes one CHPS zone and it becomes functional, the tendency to move faster into other zones and starting CHPS is so great. So what we are doing is to bring those that are doing



The Community-based Health Planning and Services Initiative (CHPS) happened when at the crossroads we took the right turn

particularly well to come and tell their story of how they are making it. This is what has brought about the concept of “Innovator Districts.” One innovator district has been identified from every region and these have been brought together to document their stories. We are also using the yearly national health forum to reach out to all districts and share ideas for moving forward.

What are some of the monitoring tools used by the PPME in the CHPS process?

Well, the most comprehensive one is the 90-day cycle collection of data from the districts. This is a set of questionnaires that districts fill in and submit to the PPME Secretariat. These are analysed and give us a fair indication of how things are on the ground. This is complemented by a field team that visits trouble spots to study the situation and submit reports. We do an average of two regions per quarter which is not enough. When we analyse the data we upload the results onto the CHPS website www.ghana-chps.org then copy the same information onto CD-ROMs and pass them around to all districts so that everyone has an idea of what others are doing. So far, that is the system in place and everything appears to be working just fine.

Are the reports submitted by districts always a true reflection of the situation on the ground?

It may be difficult to say that step two or three in this district has not been followed. Our monitoring system is not that of policing but of supporting. The team is able to spot some inconsistencies in reporting and help correct them. For instance, an entire region reported that almost all their districts had started CHPS. But the monitoring team realised that where a community-based surveillance system was in place they called it CHPS. We said, according to the definition, this couldn't be called CHPS. We managed to correct such misleading impressions and moved on.

What will you call “essential logistics” for a CHO going on posting to a community?

A short list of basic personal logistics include: cooking utensils, stoves, radio, living room furniture, including

beds. When it comes to the service delivery aspect the motorbike is key; the cold chain equipment system whereby we have the kerosene fridges for storage of vaccines and then the ice chest that the nurse takes around. And of course, a BP apparatus. These are the basic items for service delivery. We are in the process of getting a comprehensive list of essential logistics based on the minimum equipment that districts are presently using. I should think so. One clear example is getting resources to construct CHCs. Some districts have been able to engage the district assemblies to use the HIPC funds to put up CHC. Others have linked up with NGOs and development partners to assist in this direction. A group of districts have succeeded in convincing communities to give up old buildings such as post offices for renovation into CHC. Some districts have developed forms for referral cases for the CHO. As the CHO goes on her daily rounds and comes across cases that she cannot deal with, she refers to the next level. Since the referral points recognize these forms, the bearers are given prompt attention. Patients and clients have begun to trust the system—they are referred by a CHO at the community level and when they arrive at the referral point they are given special treatment. These are a few creative ways of delivering service that clearly, others can emulate.

Any frustrations?

Many! But I have my eyes permanently fixed on the future. So my frustrations don't easily get on the way.



The cold chain is crucial in the community health officer's (CHO's) list of essential logistics

Our service delivery strategy is gaining national and international recognition by the hour. Geographical access to health care services has been largely bridged and community members across the country continue to testify to the crucial role of the resident nurse. Our documentation resources, *What works? What fails?* and *Putting Success to Work*, have endeared CHPS to a respectable domestic and global audience. I feel a certain weight of responsibility to make the process work well. The health systems in most of our neighbouring countries have failed. In several instances the infrastructure has been devastated. Together, these have compounded the problems of deplorable access to health care for millions of rural people in the sub region. Do these people know that there is a strategy across the border that might work for them? I feel it is part of our responsibility to sell our product to our neighbours.

When I view the happiness I enjoy in being part of the process of making this come true, my frustrations pale into insignificance.

Now you mention *What works? What fails?*

Have you identified any gaps in the series that need to be filled?

As a matter of fact the series is working well. It's a simple two-page document that does not have to take too much of your time to read. I think that was the whole idea behind its development—to make it simple and attractive. The gaps have to do with the new things coming up in all the districts all over the country that *What works? What fails?* is not capturing. That is why we are encouraging other districts to have their own newsletter series to document their work and also share experiences on what they are doing.

Who's who

Volume 2, Number 11, 2002

THE BRAINS BEHIND THE GAINS

Professor Fred Binka was Director of the Navrongo Health Research Centre (NHRC) and principal investigator at the launch of the Community Health and Family Planning Project (CHFP). He is presently the Executive Director of INDEPTH. He discusses his work.

What is the link between the CHFP and the Community-based Health Planning and Services Initiative (CHPS)?

One thing no one ever realises is that the CHFP experiment was not directed at CHPS. That was not the goal. The experiment was to find out how to improve family planning (FP) uptake in a rural setting like Navrongo. The service delivery component only came in when we realised that it was indispensable to the success of FP promotion.

How did it all begin?

At about 1992/93 the idea came up that there was a huge demand for FP but there were no supply outlets. It was thought that a trusted person in the community could supply contraceptives to satisfy this unmet need. That is how the Community-based Distributors (CBD) system started. It was this type of experiment that United States Agency for International Development (USAID) was going to fund. The original CHFP study started in Bolgatanga District. The report was titled “Let our children live first.” It was a multi-district FP uptake study for which Dr. Odoi Agyarko, Dr. Sam Adjei and others had done preliminary work. Through Jim Phillips of the Population Council we got wind of it. We advised



Professor Fred Binka looking at the Community-based Health Planning and Services Initiative (CHPS) with a different pair of lenses

that they needed an innovation—a service-delivery component—but the Ministry and the sponsors were not interested in funding that. Their aim was to supply commodities. For example, USAID was not willing to pay for the Motorbikes for the community health officers (CHOs). They thought that was a big commitment. The first motorbikes were therefore bought by the Rockefeller Foundation. The full range of primary health care (PHC) was incorporated and we took precautions to ensure that FP was in the front seat. Unexpectedly, when the project took off the other components of health service delivery took the front seat and FP took the back seat even though it was one of our main outcome measures. Now everyone is talking about service delivery, about CHPS, and not FP.

What was the Ministry's role in the CHFP?

The Ministry's role at the beginning was very obstructive. Their major concern was that they did not want us to run an experiment whose results would not be useful. Secondly, they were not willing to allow community health nurses (CHNs) to treat patients because they have only been trained to provide promotive and preventive care. So there was a lot of debate.

What really was your point?

Our argument was that in rural communities people cannot differentiate between a nurse who provides preventive care and one who provides treatment. If a child is sick the nurse cannot say "well, I have not been trained to treat malaria." We also drew inspiration from the Ministry's own concept of choosing people from the community and training them to treat minor ailments. Based on this we said we could also retrain the CHN but the Ministry was adamant. We insisted that as a research institution we had the mandate to try things out in order to inform policy. We have been vindicated; today nobody is batting an eye about CHNs going to communities to treat people.

Certainly the Ministry needed to be sure that it would work?

I agree but I tell you what, the world has moved on. Currently the biggest disease in this country is malaria. Even at the World Health Organisation level there is an agreement that malaria treatment should be at the home. So programmes are out there to help mothers treat malaria, how much more a health worker?

Somehow, it looks like this country is not prepared for CHPS.

No. It is not that people are not prepared for CHPS. CHPS in one way or the other has been tried before in this country. But CHPS is like any other national programme; it does not get off the ground until someone brings in a huge sum of money.

So what's unique about this one?

What is unique about CHPS is that it is the first home-grown intervention that we have developed ourselves. It is not something that was found somewhere and a donor is trying to introduce in Ghana.

If CHPS is our family drum, why are there problems in beating it?

We had demonstrated CHFP in a carefully monitored and controlled setting in the Kassena-Nankana district (KND) in Northern Ghana. There are other issues that needed to be addressed at the regional level before we went countrywide. I have always advocated that the first thing to do would have been to scale up the CHFP in the whole of Upper-East region and learn some of the lessons in trying to move the CHFP beyond the district. Fortunately Nkwanta had also demonstrated that Navrongo was replicable in other parts of Ghana using resources within the system.

What can Navrongo do to help CHPS move?

Navrongo should continue to set the modalities for implementing CHPS and research into common problems of implementation. Cooperating Agencies are now providing technical support for something they have not done anywhere in the world. Why should someone else be giving us technical support for



Binka estimating the size of the problem

something we ourselves developed? It is Navrongo which should be providing that kind of support.

Does it have to do with who pays the piper calling the tune?

Absolutely! But you shouldn't completely blame our development partners alone. The Ministry, which should have been projecting Navrongo, is not doing it. I have been at meetings on CHPS where Navrongo is not even mentioned. I have been one of the key people who designed the project but I sit here in Accra and when there are meetings concerning CHPS I am not even invited! We have spent valuable time since 1993 tinkering with the idea till we got it right. You cannot say someone arrives now from somewhere and understands it better. There are many problems we went through that have not even been documented.

What were some of the problems?

When we started CHFP, it took some communities three months to start. You know how long it took the longest community? Two and half years! The thing is, communities work at their own pace. Their major preoccupation in life is to find food and then shelter before they think about health. If I tell you the processes we had to go through to make sure all the communities were part of the programme you would marvel.

What is the way forward?

I believe charity begins at home though it must not end there. Why can't Navrongo for instance go to the (Upper-East) regional health administration and tell them, "look, we have demonstrated that this thing works, we have the expertise, and we can help you move CHPS into the other five districts." There is no reason why you would not get attention. If Navrongo can do this for the Upper-East, before long you would be in a position to help Upper-West, Northern region, and the rest.

Who gave you a push when you needed it most?

There are quite a good number of names but I can't mention all of them here. Dr. Moses Adibo's contribution was outstanding. He gave us all the political

support to get CHFP off the ground. He had been Regional Director of Health Services in the Upper-East region so he readily understood what we were trying to do. But just when we were about to start he went on retirement but he continued to guide us with his experience.

What are your impressions about the *What works? What fails?* newsletter?

It represents a brilliant step by Navrongo to tell the whole world about one of its most remarkable research findings. Navrongo deserves congratulations for the good work done.

Volume 2, Number 12, 2002

WHOSE CRAZY IDEA WAS IT?

Dr. Moses Adibo, former Deputy Minister of Health, discusses his leadership role in the development of the NHRC, CHFP, and CHPS.

You know the Upper East region very well. Tell us about the opening of the Chiana Health Centre.

I came to the then Upper Region in October 1972 as the Regional Director of Health Services. Chiana Dressing



Bringing political weight to bear on health care delivery

Station had just been upgraded into a Health Centre. There was a young man who had been trained for six months at Kintampo as a Health Post Attendant. I sent him to Bolgatanga for retraining to enable him to man the laboratory. Then I sent a midwife and CHNs. I introduced them to the Chief and said, "Go and provide doorstep services and tell the people that a Medical Assistant is coming soon."

Where were you when the CHFP started taking health to the doorstep of the people?

When the CHFP started in 1994 I had just retired from the Ministry of Health (MOH) as Director of Medical Services and the Ministry had engaged me as a consultant to assist the Ministry in developing the Medium Term Health Development Strategy which I had initiated.

Whose crazy idea was the CHFP?

The initial project funded by the Population Council was to design a country-specific model of providing FP. The proposal was put together by Fred Binka, Jim Phillips, and Korshie Nazzar.

So CHFP was another attempt at promoting FP?

Exactly! When it started the nurses lived in the community and visited homes providing health education and FP services and advice to the family as a whole and not just to women. When we started promoting FP in Ghana in 1969 the strategy was targeted towards women with the belief that when the woman was convinced she would be able to convince her husband. Unfortunately, however, the men just ignored what the women said and nothing happened. We had underestimated the fact that as a people we are very patriarchal. Women are not involved in decisionmaking in the traditional setting.

How different was the Navrongo approach from the 1960s?

The Navrongo approach was completely different because the nurse was now discussing with the couple in



Liaising with the traditional leadership to get the Community Health and Family Planning Project (CHFP) off the ground

their home. In that case people from outside did not know what messages were being transmitted. This time, the women were very smart. They knew their position in the home and allowed the men to lead in the discussions. They knew that once the men were convinced, things would work. And things did work out to everybody's satisfaction.

And the story ended there!

On the contrary, that is where it all began! The doctors were excited and came to share the very positive findings with me. I congratulated them for a very innovative approach which was obviously yielding good results. However, I was a bit skeptical; I told them and cautioned that soon the success curve on the graph would develop a plateau. They became disconcerted and asked me why. Then I explained that the main reason why women want many children is because they know that if, for example, they have eight children about half of them would die. Now that they have been convinced to accept FP they are going to have fewer children. They would need a guarantee that if for example, they have four children, all four would survive. And the doctors asked me, "So what is the guarantee?" And I said, "The guarantee is that when the baby falls ill in the community, there is a service provider—the nurse who would provide the

much-needed care. So we should teach the nurse to handle emergencies when they occur." When they started training the nurses to treat minor ailments I said to myself, "At long last the age-old problems of lack of access to health care has been overcome."

Were people really enthused about it?

Oh yes. When I went to the field and asked the women what they liked about the nurse in the community, they said, "Oh, now that the nurse lives in the community with us when our children fall sick she's there."

Otherwise they would have to travel to the nearest Health Center or the Navrongo Hospital both of which are often too far away. Formerly, going to the hospital meant losing a whole day from the farm or doing household chores. Secondly the transportation cost to the hospital was taken care of.

That must have been a big relief?

Yes. But what really puzzled me was a remark one woman made. She said, "Now if the nurse tells me something and I forget I can ask her about it when we meet at the market place." So I asked them, "What prevents you from asking the nurse in the hospital?" Then they she replied, "But they don't even look friendly." In the hospital you are just a number but in the community you are special; you are assured of personalized services. There is trust between the service provider and the client. These experiences were an eye opener.

What did you do with those experiences?

I came to Navrongo when Prof. Fred Binka was Director of the Research Centre. I told them to organize a dissemination seminar at which the nurses would tell the world how they were doing it in Navrongo. That seminar was organized at the Novotel. Regrettably, the then Minister of Health wasn't there; the Director of Medical Services wasn't there either. In fact there was no one from headquarters who could influence policy at that meeting. I was very disappointed. Anyway, that is how we started. When I became Deputy Minister of Health I said we must scale up the CHFP across the country. That is how in October 1999 we organized a meeting at La Palm Royal

Hotel and the then Vice President came and launched CHPS as the new strategy to rapidly increase access to basic health care to all Ghanaians both in the rural areas and in the deprived/under-served peri-urban areas.

How do you feel about your role in the CHFP, which gave birth to CHPS?

I feel proud about it, and I must tell you that I am impatient that things are not moving as fast as they should.

What is holding CHPS down?

People don't understand CHPS and its importance. When we sit in the comfort of our offices in the cities, we forget about what is happening to poor people in remote parts of the country who have no access to health care. Under those circumstances when you see a nurse coming to live with you so that when you have a problem there is someone to run to, then you would begin to appreciate CHPS. If the Directors can appreciate what the poor folks are suffering they would be the first to say, 'No, let's do something about it'.

What has to change for CHPS to move?

We have been trained to sit in our clinics for the people to come to us. Under CHPS it is we who have to go to the people. This reversal of roles is incomprehensible to most health workers. So a lot of reorientation is needed. The so-called big people would have to move into the regions—into the district. They should go to Navrongo like I did. I went to Katiu, Kayoro, and to other communities to see where the nurses live; I talked to the chiefs...if they are able to do this then they will begin to understand. The other thing is that many people don't know that this nation has about 55,000 human settlements and that MOH is not operating even in two thousand (2000) of them. But then that is the size of the problem.

Do we need another dissemination seminar?

Not one but a series of them! Dissemination should be done from region to region. It is important that the Regional Minister, the entire Regional Administration as

well as the Regional House of Chiefs should be present at these dissemination seminars. They would understand the problem because every chief in this country knows the number of communities under him. Then take the census book and find out how many communities are there in the various regions and districts and see in how many of them the MOH is operating. Then ask yourself, "What do we do with the rest of the communities that the MOH does not reach?" Since it is expensive to build hospitals, would it not be better to train a nurse and put her in the community because all you need is a two-bedroom house and a motorbike?

What more can you expect from Navrongo after the experiment?

That is why I recommended that you allow the nurses in the field to come and tell their story. Now you can team up with Nkwanta because Nkwanta is the first district that successfully replicated the most important ingredients of the Navrongo experience using its own resources. Usually the problem is that people say they cannot replicate Navrongo because they do not have that much money. You can easily answer this question if you have Nkwanta with you, then they would say, well we have been able to replicate Navrongo using our regular budget, so you can also do it.

Is CHPS sustainable?

Yes, it is. But for CHPS to work it takes a lot of imagination. The Directors both at the top and at the

Regional and District levels must have a vision and be creative, but above all, they should share that vision with their staff.

Volume 2, Number 14, 2002

DANCING TO CHPS TUNE

Dr. Sam Adjei, Deputy Director General of the GHS and former Director of the Health Research Unit, discusses his work.

You haven't been to Navrongo for a long while!

Oh no, it's not a long time. I love research. I was actively in charge of research. The Ministry is not yet fully set up and I have to do many of the things myself. I have to back the Minister up with a lot of work and policy decisions. This does not leave me with sufficient time to visit the field. When you become administrator you run the risk of losing touch with the people.

We have developed the *What works? What fails?* newsletter to disseminate findings of the CHFP, which fed the CHPS initiative. We are interested in opinions of people who played roles in the CHFP or were directly concerned with CHPS. What's the main challenge in implementing CHPS?

The main issue is with translating research findings into policy and programmes for implementation. We have to continue to disseminate the findings that came out of Navrongo, which is different from CHPS, because CHPS is not necessarily a carbon copy of CHFP. Other things come in but they are building blocks of issues that came out of Navrongo. There are clear, systematic steps. The problem I have is with people not wanting to follow the steps. I have been in the system long enough to know how to move from research findings to policy to programmes and then to implementation.

What are people supposed to do with CHPS?

Sometime in 2000, we wrote the policy framework for CHPS and a draft was prepared and circulated.



Is the Ghana Health Service dancing to the tune of the Community-based Health Planning and Services Initiative (CHPS)?

Unfortunately people did not respond to the draft policy. What is happening now is that donors are taking bits and pieces.

Why is it so?

Well, for a long time there was no central leadership direction for the programme. There was a lot of political enthusiasm but that was not getting translated into the package of programmes needed to move forward. We met in Kumasi with teams from the regions to look at an action plan. The regional directors of health services came at the tail end to discuss with their teams so that we can have a common understanding of the way to go.

Remember the concept of the lead districts?

Yes of course. I kept reminding them that even in Navrongo we started off with two or three villages so the idea was to pilot with two districts in each region to get an idea of how to interpret the research findings within the policy framework on the ground.

What type of problems did the “lead districts” unveil?

Staffing problems were the first to come out. Some programme policy issues also came up. Nkwanta, for example, wanted to allow CHOs to insert IUDs. That is against policy. What is the most appropriate package of logistics for service delivery; who pays for the drugs at the community level? These were issues coming out of

implementation which needed to be tested out in the two lead districts.

Were the lead districts being closely monitored?

This was the main reason for instituting the coordinating meetings at Headquarters. The idea was to make programme heads and development partners who support the CHPS initiative meet on a monthly basis for discussions. For that purpose I have produced a summary framework of what the programme components are; what the activities are as well as mapping out responsibilities for the various divisions. As the Deputy Director General I took it upon myself to coordinate these activities. We defined the components of the programme, the service delivery package was coming in, the monitoring and evaluation element, logistics and human resources element was also coming in and so on.

The programme seemed to have been well rolled out, what went wrong?

To be frank with you, some of the project heads and directors did not grasp the programme, others were also complaining that they were not involved. I was surprised because we were at Kumasi where all these were streamlined so I expected that they should be coordinating the implementation process. I even encouraged the donors to go straight to the regions and the regional directors should take them on board. Others misunderstood this, claiming the administrative hierarchy was being bypassed.

The lead districts concept is causing anxiety now.

The issue is that the Regional Directors are not enthusiastic about the concept of the lead districts but the idea of the 2x2x2¹ was to have an area where you intensively look at issues before going to scale. If the idea of the lead district is not working we all need to sit



Dr. Sam Adjei is counting the cost of implementing the Community-based Health Planning and Services Initiative (CHPS)

¹ When CHPS was first implemented, the GHS developed a concept in which two districts within each of the country's 10 regions would be selected to pilot the strategy. In each district, two communities (or zones) were identified for the experiment. These zones were to serve as catalysts for spreading CHPS throughout the district. This process was known as “2x2x2.”

together again to review it. The bottom line is that to implement CHPS the way we want it requires a lot of money, much more money than people realise.

Where is the money to come from?

That is the crux of the matter. The Ministry certainly does not have all the funds needed. Communities would have to make a contribution before we beef that up with external funding.

Is the country really interested in CHPS?

Of course we are interested in CHPS and we are looking for ways to get around the problem of funding. Sometimes I really wish we had not used the name CHPS. It creates the impression that it is some vertical specialized structure but CHPS is just a strategy for reaching communities in terms of health service delivery. There are two things that I have done. One, community-based service delivery has become the central theme in our new five-year programme of work. The second thing that I have done is to make it also central to the Ghana Poverty Reduction Strategy (GPRS) so that if Heavily-Indebted Poor Countries (HIPC) money is made available to us that is where it is going to go. I have produced a document, which maps out a service delivery package, logistics, infrastructure development, financing of services, role of private sector, civil society, and community political leadership.

Are the GPRS strategies and yours similar?

Oh yes, they are and we have made a lot of input into them. GPRS is earmarking four regions: Upper-East, Upper-West, Northern Region, and the Central region. We have suggested and it has been accepted that deprived districts outside these regions should be included whilst the more endowed districts in these regions should be taken out. So we now have about 65 deprived districts to work with.

What crosses your mind about facilitating CHPS implementation?

Improving radio communication; expanding the training institutions to be able to train more nurses for CHPS.

We have to change the whole strategy for training; we have to look at taking people from the community, the sub-district or the district to be trained and come back and serve their communities. We have to redesign the school to make it a modular system so the students go to school for three months and come back to the communities and serve for another three months to get a fair idea of what is on the ground. I am going to discuss the strategy paper with the regional directors and exhaust the contents for implementation.

What can Navrongo do for CHPS?

Most of the donors who say they are providing technical support have not seen a village or compound before! I will be very happy if Navrongo can continue to do operational research. Mr. Asobayire or Master as we use to call him, is no more, but there are others like Rofina Asuru who have practical experience. They can constitute themselves into a team that can be used for monitoring and also for providing technical support. So that if the monitoring system picks up some trouble spots they can go and assist people to overcome them. Navrongo can also experiment with CHNs inserting IUD or Norplant. Findings from an experiment like that can inform the CHPS implementation process. If Navrongo can do all these, I'll be glad.

Volume 4, Number 16, 2004

FRANKLY SPEAKING

Dr. Frank Nyongator is Director of the PPME of the Ghana Health Service (GHS). He has direct responsibility for coordinating the implementation of CHPS, a nationwide health care delivery initiative based on findings from the Navrongo CHFP. He discusses his work.

You were the first Regional Director of Health Services to replicate the Navrongo CHFP. What motivated you to do this?

I had visited Navrongo with a couple of others, basically to look at avenues for holding in-service training for

district directors. When we arrived in Navrongo and saw what the CHFP was doing, we immediately decided that this was a place we would like to train district directors. We also realised the project was an efficient way of extending services to the poor and could be replicated in other parts of the country. When we got back we began to put together a programme. At that time Dr. Moses Adibo (then Deputy Minister of Health) too had begun to disseminate results of the CHFP. It then dawned on me that the programme in Navrongo had good prospects for increasing coverage of health services. So I went back to Navrongo to take a more critical look at the CHFP service delivery strategy. When I returned to the region I mobilized all the district directors, put them in a bus and drove them to Navrongo. I challenged them to look at the CHFP as a workable strategy for achieving the kind of service coverage that they had yearned for but had never achieved. That is how the Volta region took the lead in scaling up the Navrongo service delivery model.

What factors accounted for the successful replication of Navrongo in the Volta Region?

Much of it depended on regional enthusiasm and leadership at the district level. Leadership takes up to about 80% of what is required to make an innovation work in a different setting. When the district directors returned from Navrongo, I urged them to write proposals on how they could utilize the ideas they had



Dr. Frank Nyonator being cautious about where the CHPS fall



The road to the Community-based Health Planning and Services Initiative (CHPS) is more popular than the alternative

learned. About four or five district directors responded. So right from the word go the leaders distinguished themselves. Nkwanta became very enthusiastic. South Tongu and North Tongu also showed keen interest. I encouraged them to start on their own using resources at their disposal. At the regional level we also started writing proposals on how to translate the Navrongo research findings into actual service delivery. We eventually got Africare to support the region and sponsor three districts to replicate Navrongo. Africare wanted to monitor closely what they were doing but felt Nkwanta was too far from Accra so they chose to work with South Tongu and North Tongu. Nkwanta was left to struggle on their own. The Navrongo experiment was not a blue print of how things should be done. It's a trial-and-error method. When the district directors returned from Navrongo the District Director of Nkwanta went back about five more times. He kept at it till he got it right.

What were some of the difficulties encountered?

We had two scenarios the Nkwanta—one which proceeded solely on district-based resources and the South Tongu and Akatsi districts which had some project support. There were also administrative bottlenecks. For instance, how motorbikes and incentives were to be provided for the nurses going to live in the communities was not immediately known. Nkwanta came out with its programme and the regional directorate supported them. Some districts felt constrained by the absence of clear guidelines for dealing with the new concept. The regional office had to give them some backing and urged

them to use part of their internally generated funds. The other challenge was how to deal with the project-supported districts. We had our own arrangements and the funding agency had their own as well. How to balance the two seemingly divergent interests though aiming at the same goal was a complicated issue. There were a lot of tradeoffs but we eventually came to some understanding. With Nkwanta, we provided only administrative coverage for them to move but in the other districts there was a lot of negotiation. We then began to develop proposals as to how to monitor the work that was going on. We sold our idea to the other regional directors about the need to put in place some monitoring mechanism. They agreed that the Volta region should blaze the trail in this exercise. We haven't seriously thought of these as difficulties because it has all been a learning process.

What is your idea of non-negotiable steps in the CHPS implementation process?

We must recognize and accept that CHPS is a community-based health care delivery programme. That is why we started by building capacity for community mobilisation. Through the District Health Systems Operations workshop, an in-service training programme for district health workers, we had Navrongo prepare a module on community mobilisation which every district that participated in the training had to go through. So it came to me as a big surprise that most of the districts that were reporting to the PPME were not engaging the communities in the process. CHPS is a process whereby the communities determine what services they want and how they want them provided. So it is important to get the communities first of all to be aware of what the possibilities for delivering health services are and to accept to spearhead the process of decentralizing access to their doorstep; to assist the CHO to relocate to their community and provide services. If this process of sensitising and engaging the communities has not been followed through, frankly speaking, you are not implementing CHPS. The non-negotiable steps include the District Health Management Team (DHMT) analysing its situation and determining what areas are

poorly covered and how the CHPS strategy can bring improvement. The second step is for the DHMT to build consensus among its members. Then dialogue ensues with community members in the selected zone. When this is properly done, issues pertaining to getting a dwelling place for the incoming CHO becomes easy to arrange because the community has to contribute resources no matter how small. Next, the community identifies volunteers to assist the CHO in her work as well as agreeing on how to compensate the volunteers' efforts. Payment of the volunteers by the health bureaucracy has not worked in the past and the system was not going to walk that path again.

Why do you think some are proceeding with CHPS implementation this way? Did you foresee this happen?

What we have realised from the monitoring and evaluation (M&E) results is that some districts have missed the concept they just write letters posting nurses to communities and asking them to go to their duty post. A good number of districts complain that their biggest obstacle is how to get Community Health Compounds (CHC). This creates the erroneous impression that CHPS is CHC dependent. But now it is clear that the issue arises as a result of failure to engage the communities to make a contribution. We studiously broke down the implementation into steps—some 15, others 24—grouped into six milestones. These are meant to be a guide the steps were not cast in steel to be followed in a certain order. CHPS is a process of learning by doing and we amply made this clear. The steps can be followed in a certain pattern depending on the situation. We knew there would be a lot of innovation in the process of implementing the new concept but the managers on the ground just had their style. It has all been a learning process and as we proceed we get a clearer and clearer sense of direction.

What is your strategy for engaging development partners?

We have tried to get donors to identify with and support the development of manuals for training of CHO, provision of logistics such as motorbikes (which is capital intensive), communication systems, and assistance with monitoring and evaluation. We have tried to discourage

development partners going directly to districts and trying to carve out what support they like to offer. We need to standardize and synchronize the way CHPS is implemented—and donor support is best coordinated from the national level.

Volume 2, Number 15, 2002

BEATING AGONGO'S "GONG-GONG"

The Upper-East region is the most advanced in CHPS. Regional Director of Health Services, Dr. Erasmus Agongo discusses his successes.

How have health indicators changed since you have been in charge here?

A lot. Service coverage has significantly improved. In 1994/95 immunizations coverage for instance was around 40%. Today it ranges between 70–90%. Disease surveillance has so significantly improved that epidemic-prone diseases are now very well known. Public education has also improved remarkably. OPD attendance, which hovered around 20–30% in 1994/95, has risen to 50%. But this is not necessarily because I have been in charge. These achievements are significant, if you consider the fact that we have to contend with consistently decreasing numbers of health personnel.



Dr. Erasmus Agongo: No outside interference in the Community-based Health Planning and Services Initiative (CHPS) process

What are the obstacles to doorstep health care?

The main thrust of the CHPS is the health worker placed in the community to offer door-to-door services. Unfortunately the CHNs who are suitable for the CHPS programme are seriously lacking. The number of CHN in this region for instance has decreased by 50% since 1995. The human resource is the critical factor in community-based health service delivery. The other thing is the idea of bringing people from outside to train staff for CHPS who may not be conversant with how the concept works. It kills local initiative. Those who are most qualified to train people in “community entry and mobilisation” for instance are the NHRC. It is they who should be providing that technical support needed to get CHPS going.

How about the concept of the “lead districts,” how is it helping?

The “lead districts” idea has impacted negatively on the CHPS process in this region. We adopted findings of the Navrongo Experiment in 1999 even before the nation adopted CHPS. This was done in the presence of the Regional Minister, the Regional Health Management Team, the DHMT at a conference addressed by Navrongo. All the districts agreed that CHPS was the way forward and went ahead to start in the first year. Many were slowed down by lack of health personnel. This was the problem with Builsa district. Bawku West put a nurse in one community but when she went to school the programme stalled. I am glad to say a new nurse has been sent there and the programme is running smoothly again.

Why shouldn't selected districts test CHPS out so lessons can be pick from them?

In the first place the district should not be the focus of CHPS. The focus is the community. The “lead districts” concept takes a lead district from every region, two lead sub-districts from every district and two lead communities from every sub-district to implement CHPS. What happens when you have districts or communities outside these lead districts that are ready to take off with CHPS? They will have to wait because they are not even included in training programmes! Do you get my point?

What is your point?

I am saying give capacity to all districts so that they can implement CHPS at the rate that resources allow. CHPS is not a programme for health workers alone. It involves the community, the district assembly and the traditional authority. You need to bring the district assembly on board and constantly keep them aboard because they have the resources to put up the structures or contact NGOs that can assist. Under the "lead districts" concept, CHPS is an entirely MOH affair.

In spite of the difficulties, Upper East is the most advanced CHPS district, what's your secret?

The secret is that both the health worker and the community members are enthusiastic about CHPS. The district assemblies are also committed. We want our nurses' dwelling compounds to be more decent than the ones in Navrongo. All the compounds should also be provided with electricity or solar energy. These are to motivate the nurse to stay in the community but the communities are poor and cannot afford these necessities. Apart from communal labour the community's major contribution so far is the patronage of services.

CHFP was not directed at CHPS, remember?

It was directed at FP, but if you look at what the nurses are providing, it is more like family health services and that includes FP.

So what tells the CHFP and CHPS apart?

CHFP was a research project to acquire generalisable knowledge whereas CHPS is a programme to expand health service to communities. The components are the same. There are only some modifications.

What for instance can be modified?

Under CHPS, CHO will be doing more of first aid than was the case under experimental conditions. The regularity of compound visits could also vary depending on the size of the area of coverage. The number of people at a CHPS station could also vary depending on the size of the community. In very large communities the nurses may be more than one to share responsibilities. Some nurses'

residence may be fitted with delivery beds so that mothers can be safely and conveniently delivered of their babies. CHPS can also be modified to fit an urban setting. Nurses may not stay in a community but could be given responsibility to oversee health there as the community's CHPS officer. As such she will be able to organise community meetings just like it happens in rural settings. These are possibilities that deserve serious consideration.

What is needed to make CHPS sustainable?

CHPS is sustainable if government makes a commitment to pay and motivate the staff to stay where they are posted. The bill is manageable if you look at what is spent on other things. CHPS officers should be given the needed logistics to work. Transport is particularly essential. Durable CHC structures are essential.

What are you doing to make CHPS sustainable in the Upper-East?

First of all we want to make the communities own CHPS. We have mapped out every district into CHPS zones and asked them to come out with a CHPS implementation plan. We want the communities to take the initiative. If they have a sense of ownership of the process, they will keep working at it till they get it right. Our role is to facilitate the process and pay regular monitoring visits to CHPS areas. CHPS has consistently featured in our annual review seminars. This is to emphasize the importance of programme.

How many communities can you say are implementing CHPS in the Upper East region now?

Available reports indicate that almost every community is in for CHPS but these are at various stages of the process. There are over 50 zones implementing CHPS. We urge people on but we keep insisting that CHPS is not to put a nurse in the community to run a clinic. CHPS is a work plan that makes the health worker part of the community.

You don't seem to be making good use of Navrongo?

There is a lot of interference from outside that makes it difficult to tap into Navrongo's experience. Bawku West has been able to contact Navrongo directly and they are

doing fine. A lot of things need streamlining. The people started with Navrongo and suddenly they have to deal with a different team. So CHPS is seen as a different programme altogether. The idea of training trainers for the region who will then train others in the district is not helpful. It has a lot of implications. First of all each district has its peculiar problems. Secondly nurses would not appreciate their colleague nurses coming to train them. It is different when nurses are taken from across the district and trained. We need to be sensitive about some of these things. Basically that has been the reason why we have not made good use of the facility in Navrongo. But henceforth, more and more districts will be coming especially so when it does not cost anything to tap Navrongo's experience.

What can Navrongo do to speed up the process?

One thing is to work to improve the information system of CHPS. The monitoring team from the Volta Regional Health Administration is doing a good job by noting down the processes. I am also encouraging my people to take note of the outputs—how many antenatal patients seen in CHPS areas, level of immunizations coverage, number of sick people seen. If you only look at the process indicators it will not make people focus clearly on what their goals are. Navrongo can also lobby people to come and support CHPS in the country. Then there would always be new ideas and the dissemination of new ideas is helpful.

Do the communities really know what is going on?

Yes, they do. They may not call it CHPS but they see that health has really been brought to their doorstep. That is why other communities are now clamouring for CHPS. With a good number of nurses we should have been far away in CHPS.

Any immediate plans to raise the numbers of health personnel needed to run CHPS?

Our hope is on the Day CHNs Training School that Navrongo is trying to establish. The GHS has also seen

the need and has tried to increase intake in the existing training schools. Products of the Kintampo Training School could also be candidates for CHPS. So there are two ways out; increasing intake and opening new schools. The volunteer system should also be strengthened to support the nurse in the community.

Volume 2, Number 16, 2002

WHO NEEDS RESEARCH?

Dr. John Gyapong, Director of the Health Research Unit of the MOH, discusses his work.

You must be proud to have run an experiment whose results have been used for policy.

Certainly, that is a good thing. I think the findings make it clear that if you put trained health workers in a community to provide prompt health services to the people at their doorsteps, their health status would improve significantly.

The Regional Directors of Health Services have produced a report on CHPS which indicates that there is something about CHPS that just does not tick.

I have not seen the report but I assume they are probably looking at implementation issues. Under research



Improving health through research is a lot to smile about

conditions you want to establish that it works so resources, both human and material, are mobilized to ensure that the experiment is well done.

What are the implementation issues?

We are talking about health personnel at the community level as the primary thing. The question is, where are the health personnel to put in the community? We started in Navrongo using CHNs. How many community nursing training schools are available? During the initial phase of the scaling-up process we did some calculations and realised that the rate at which our nursing training institutions train health staff it would take us over 20 years to train the required number of staff for CHPS.

This is a policy so you must have been looking for where to get the nurses. For instance, Navrongo is putting together a proposal to start a nursing training school.

That is a step in the right direction. Policies only provide a framework for implementation. What is needed is to set guidelines or boundaries to determine what people are allowed to do and what they are not. The fact that the health sector appreciates the CHPS project does not necessarily mean that overnight every community is going to have a health worker placed there.

Every community has a teacher so why shouldn't every community have a health worker?

Yes, it makes sense, but look at the number of teacher training colleges and the numbers they produce. The attrition rate in the health sector is very high. Many of the nurses have left in search of greener pastures abroad. Apart from that we also have a situation where nurses are concentrated at facilities where they provide secondary or tertiary care. This is necessary though. Take Navrongo for instance, you can decide to put CHNs or any category of staff in all the communities. But immediately somebody falls ill and it is beyond the CHN's ability they think of going to Navrongo hospital. And if you go to Navrongo hospital and there is no nurse, there would be chaos. So you must not just rush to start with the periphery, you also have to make sure that the secondary

and tertiary care systems are in place to support the nurse. We have taken an inventory of what we require, the question is, where are the resources to come from?

For CHPS to work, the community must own it. The community must understand it and look at it as their strategy to address their health problems.

It is good to have community involvement, participation or however you term it. We must look at what the community must own. If you look at the concept of CHPS, the community must be responsible for providing certain basic things for a health worker put in a community. The Navrongo experience has shown that the community members can provide accommodation and other necessities to make the health worker feel at home. But the community involvement does not solve the problem. Somebody must supervise the health workers there. Somebody must make sure that drugs are available and the right things are done. And this is a health systems issue. The community must own it, I agree but at the end of the day ownership from the technical perspective must come from the health sector.



Dr. John Gyapong has a lot in his hands to back health policy

Can communities implement CHPS without support from development partners?

The first point is how much it is going to cost us to implement this strategy? As far as I know, that planning exercise to determine this has not been done. There is the Government of Ghana (GOG) fund which is what the finance ministry allocates the health sector. Then we have the Internally Generated Fund (IGF) but these are insufficient—so whether we like it or not the health sector needs assistance from development partners.

Under the Navrongo experiment there was the health committee, health volunteers, the CHC and the CHO. Would you say these are the core components of any community-based health care delivery?

I think we should look at the data that is available. There is some debate as to whether the role of the village volunteer, is not even detrimental in terms of adverse mortality in those communities. You know that sometimes when you empower the volunteers, out of zeal they go beyond their limits. I need to see that kind of data. But having said that, I think it would be very useful if the health worker has a partner in the community to work with. That would make things a lot easier. From CHFP to CHPS, how does Navrongo fit in? I personally think that Navrongo has a role to play in terms of providing technical expertise. But we must be careful Navrongo does not begin to launch CHPS. Otherwise, we cannot concentrate on the research that we are supposed to be doing to inform policy formulation. But there is also the aspect of policy implementation. When policy is being implemented, operational research is carried out to inform the process, but I don't believe Navrongo should be taking the lead in the implementation of CHPS because its mandate is research, not implementation. So my point is that if there are some research issues that come up in the course of the implementation of CHPS, then technically Navrongo comes in. Navrongo can also provide technical support to districts implementing CHPS. Technical support pre-supposes that there is a group who knows it all. And if there is a group who knows it all, it must be

Navrongo. I see Cooperating Agencies have become technical advisors on the CHPS project. That is unacceptable. We cannot develop a system ourselves and someone else comes to tell us how it works!

Who should say Navrongo is best placed to provide technical support to CHPS?

If there is a group of people in Navrongo who have the expertise in supporting the running of programmes, or even people who are in the position to provide the technical support that we are taking of, I think that we would have to look at it carefully. I haven't tried that before but I think that is something that can be experimented. We could look at the possibility of having some core group of people who are in the position to advise on vital issues regarding CHPS. This would not necessarily be a full-time job. It should be a standing team of people who have run the Navrongo experiment from the beginning and know enough what it entails to be able to offer advice on authority.

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CHIPPING CHPS TO SIZE

Dr. Alex Korshie Nazzar, former principal investigator of the CHFP and now at the Health Strategy Development Unit of the GHS, discusses his work.



Dr. Korshie Nazzar feeling the impact of improved health coverage on child survival

You have been directly in charge of the CHFEP

Experiment before, what were the problems with the scale-up and how did you manage them?

The problems of the scale-up of the lessons from the CHFEP had to do with understanding the import and policy implications of the findings from Navrongo.

What is your understanding of CHPS?

CHPS is a strategy to deliver PHC services based on the conviction that communities cannot and should not continue to be passive recipients of health technology but must be active players in the full process. What people seem to be doing currently regarding CHPS is putting a nurse in the community and saying they are implementing CHPS. The concept is about extending health care planning and service delivery into the community with the community itself mobilized to accept and utilize the services. The nurse is sent to the community to perform three main functions: (1) "Reconnaissance Agent" who goes to the community to better understand the community needs, and to communicate these needs to the sub-District to enable the DHMT to plan a more effective and relevant service delivery intervention; (2) "Technical Assistance" provider for better home management of common ailments through health education activities, and (3) "Change Agent" to facilitate the adoption of better health-seeking behaviour.

What's the best approach to CHPS implementation?

The first step in getting this going is building understanding in the community. First of all you must understand that you are going to make a major change in the pattern of service delivery. Usually when you talk about health in a community, members immediately tend to think and talk about the availability or otherwise of a fixed-facility Health Centre or a Hospital, because that is the paradigm they have always known. But that is exactly the paradigm you want to change. You would discuss with them that you are talking about health but you are not talking about a fixed facility. If you don't go through that process thoroughly to get the community to understand and accept this new concept of health care delivery they will be dissatisfied with the nurse when she eventually comes to live in the community.

Are you talking about a mobile clinic of sorts?

No. We are talking about preventive health. The primary purpose of the nurse going to the community is the provision of health education for disease prevention and health promotion. Her presence in the community and her consequential knowledge of the health conditions of the community will assist the sub-districts in identifying the problems that the sub-District Team Managers will plan to address adequately. The concept is not to put a nurse there to "solve" the community's problems. The nurse cannot do it—no nurse can, without the support of the sub-District team and the community; do what is currently being conceptualized as the role of the nurse in the community. No nurse can go to the community and single-handedly do deliveries, treat malaria, treat diarrhoea, carry out immunizations and so on. It cannot work. We were conscious of the fact that once the tag 'nurse' is put on the community health service provider, it would raise expectations of clinical services. But in actuality her main training had been in preventive health care. So it was decided that while in the community providing health education, the CHN should be redesignated as CHO and equipped to provide basic treatment for minor ailments—but this was never to be her main preoccupation in the community. She was never to replace the Health Centre. In fact the Health Centre is still the backbone to the CHPS strategy.



Dialogue with the community is central to community-based health service operations

Is that the reason why CHPS is running into problems?
There are many reasons why CHPS is running into problems.

Community based... Health Planning...

...and Services. People distinctly hear “service”; they don’t hear “planning” so clearly and even if they do the real import is lost on many. They equate “service” to clinical activity.

A typical community does not have complex health problems. In KND, if a nurse is trained to do deliveries and treat malaria much of the health burden is taken off.

That is where the concept of CHPS has been misconstrued. CHPS is a service delivery strategy beginning at the periphery. Once you improve service delivery at the periphery the services at the sub-district have to be improved too. The structures around to which the nurse can refer cases must also be improved. There must be efficient communication and regular supervision. Here I am talking about effective facilitatory supervision where you go to find out what difficulties the nurse is facing to see if the health delivery strategy of the sub-district is on course and to offer assistance to make this happen. As a “Reconnaissance Officer” in the community she is best placed to let the sub-district know how well-targeted their plans and interventions are.

What is the difference between CHFP and CHPS?

CHFP tried to find out which ones of many strategy options work. CHFP tried to see what happens when you involve communities in health planning and service delivery. CHFP dialogued between health professionals, political leadership, and traditional leadership to look at options to widen access to and raise the quality and efficiency of health care delivery. That is why the experiment looked at various options and combinations thereof. In Cell I only volunteers were put in a mobilized community. Cell II had only the health worker without mobilizing the community and in Cell III we combined the strategies in Cells I and II. Cell IV was the control where no intervention took place. In short, CHFP is an experiment whose results uncovered new ways of doing things. CHPS is an innovation that took the CHFP

findings and fashioned out a strategy for delivering health service outside experimental conditions.

What does it take to move from CHFP to CHPS?

You need to develop counterpart technologies, which were relevant lessons learned from the CHFP experiment that needed to be pointed out and developed further. There was a strong level of community dialogue, dialogue with the nurse, supervision, education, motivation and many others. All these were under experimental conditions. Some failed, some performed poorly, and others excelled. The lessons from these were looked at and formulated into a feasible strategy and improved upon for delivery within a nonexperimental arena. This ensemble of strategies constitute CHPS.

Have we really got it wrong?

Yes we have. It’s like you make a car. The beauty of the car attracts people and they buy it. They take it away and try it. It starts and moves a little distance then it stops. And the conclusion is that the car is not good.

The customer does not have the manual!

He hasn’t taken time to study the manual. When we went outside of Navrongo and started disseminating findings of the CHFP, concerns were raised that this thing could only work in Navrongo. We emphasized that what mattered from the experimental findings was the concept of community dialogue and process of community consultations and not the particular style of community organization that was used in Navrongo.

Could it be that Navrongo is not disseminating properly?

No, no. This thing was talked through carefully. Communities have a lot of resources in terms of suggestions, capabilities and abilities that can be mobilized using our professional skills. This is the fact Navrongo is disseminating. When it came to scale up, we looked back and honestly realized that we didn’t arrive at the end product without problems and that was communicated clearly. Dialogue with the communities is indispensable to the success of CHPS but that is exactly what people are sidestepping.

How do you see Navrongo pulling all these loose ends together?

I don't want to sound presumptuous. But put your ears to the ground. If you look at what is happening to the CHPS scaling-up process, there are lots of issues for clarification, investigation and further research.

Volume 3, Number 4, 2003

WHO'S IN CHARGE HERE?

Ms. Rofina Asuru, Principal Investigator of the CHFP, discusses her work.

What does it mean to be the Principal Investigator of the CHFP?

Everything. It ranges from developing concepts, getting these concepts on paper as a proposal, sourcing funding, and then getting into the field to do what you have set yourself to do. It involves seeing to it that the work is done according to the protocol documents and meeting deadlines. It involves submitting technical and financial reports. Above all, it involves writing scientific papers and publishing them!



Ms. Rofina Asuru—happy to be in charge



Two pairs of lenses are better than one: Ms. Asuru sapping experience from Dr. Erasmus Agongo

As a professional nurse, was the CHFP necessary? Did we not know that deploying nurses to village locations would improve access to health care?

As a professional nurse I think the CHFP couldn't have come at a more opportune time than when it did! We definitely knew that deploying nurses would increase access to health care. Our experience with the PHC concept where village health workers were trained to offer accessible health care to communities tells us this. The question was how do we do it? When I was actively in service delivery, it was clear that anytime we were able to keep our outreach schedule for the month, service indicators—especially the Expanded Program on Immunisation (EPI)—increased tremendously. The project therefore demonstrated that it is not just enough to post a CHN to a village location but requires support systems from the family, supervisors, peers and more importantly the community.

Educational attainment in the KND is low. How did you get started?

I remember a paternal cousin who took me to school. He was already in Achimota by then. I really wonder if I would have gone to school but for him. The fact that I was a girl even reduced my chances. Havening said that, let me also say that my father really sent this cousin of mine to school and the fact that we are only three girls born to our parents I might have still stood the chance. My first week in school was not pleasant because the other

kids beat me a lot! Subsequently I made friends and started enjoying school. It was not easy because I had to do the household chores alongside my schooling. The teachers too did not spare us so there was no truancy.

How did you become District Director of Health Services (DDHS) in Builsa District?

I was asked by the then Regional Director of Health Services, Dr. Erasmus Agongo, to take over the Builsa District when the substantive DDHS was going for an MPH course. I had then just completed my first degree at the University of Ghana, Legon.

Sharing public health and clinical programmes, how did you manage that?

Well, the staff were very cooperative and ready to work. All I needed to do was to get them involved and acknowledge everybody's contribution. And it worked.

What were the major challenges you encountered when you were employed in the NHRC?

One major change I faced was finding my exact role. When I came here, it was like I had been working here before! It is true I worked closely with the Centre while I was in the DHMT but then when I was posted to the Centre, I was attached to the CHFP project; I did not know exactly what I was to do. When I reported to Dr. Korshie Nazzar, the then Director of the Centre, I asked

him what I was to do. I remember him telling me that nobody has a job description here. He asked me to go and see Master, the late Asobayire. I had to decide what I wanted to do.

What do you enjoy most about your work?

I don't know if I should say it is enjoyable. It is interesting when everybody looks to you as the head of the project to make the crucial decisions when in fact sometimes you are not sure if these decisions are right. What I enjoy most about the work is attending the community durbars. These are occasions for community members to discuss health issues. I particularly enjoy very much the debates between the men and women about FP.

How do you combine family, friends and fieldwork?

It is not easy. I have little social life and I have lost a few friends because I rarely visit them. Everyday there is always unfinished business! My family is trying to cope with my continuous absence.

CHO often seek community placement even though work is hard and days are long. What keeps them motivated?

Several factors keep them motivated. One is the realization that their presence in the communities is much appreciated by the communities. Secondly, they are doing something different that draws their colleagues and other people in and outside Ghana to visit them. Thirdly, they are independent and plan their own work routines and take responsibility for their actions. Lastly I will say the monetary reward.

Everything that is written seems to be saying that nothing failed in the CHFP. Is that true? What has failed?

I don't think it is true to say everything in the CHFP works! The project has performed creditably in mobilizing communities for self-help but in the case where there is really no strong leadership, the project has not been able to sustain the spirit. Construction of traditional compounds for CHO does not work!



Ms. Asuru in a dialogue with the community

How do you intend to end the CHFP?

The CHFP will end with a scale-up to the rest of the district, especially the control area. As you are aware, the experiment covered only 16 communities. We still have about 19 communities in cells 1 and 4 that need to be covered. It is only fair that all those who participated in the experiment are given a share of the benefits.

You always seem to be playing two roles at a time—now you are also the Principal of the newly established CHNs Training School in Navrongo. How do you combine the two jobs?

With the help of others, things are going on fairly well. At the time when the school fever caught up with everybody, we didn't really think getting ahead would be a problem! Then we woke up to the reality. Well I was asked once again by the then Regional Director to hold the fort until a substantive head is found. I have since been acting and I must say I owe our daily success to the dedicated support of Mr. Moses Nanang and Mrs. Olivia Fatchu who are helping out. We are committed to seeing the school succeed so that others can learn from us.

Volume 3, Number 9, 2003

SAI OF RELIEF

Prof Frederick Sai, Presidential Advisor on Reproductive Health, HIV/AIDS of the Republic of Ghana, is one of the



Policymakers and researchers are committed to improving women's and children's health.

architects of the CHFP. He has served as board member for several international organisations, including Family Health International, Family Care International, Population Action International, Population Council, and the International Planned Parenthood Federation. He discusses his work.

What Ghanaian programme has been most successful in addressing the issue of sexual and reproductive health and how can that programme be replicated throughout the country?

I would think that the Navrongo Experiment has probably been the most successful. Historically there have been preceding ones such as the Danfa project, which unfortunately was more for the benefit of the associates from outside the country than for those within the country. Although the programme was a very good one in concept and was executed well there wasn't the link up to the Ministry [of Health] to the extent that findings could be implemented and extended or disseminated and put within the system. The Navrongo one has been successful because it has been able to overcome this particular difficulty. Even though people like Jim Phillips and his associates have been involved, the programme has been made essentially Ghanaian owned and because it is Ghanaian owned, Ghanaians have been anxious to see to it that the lessons are applied as soon as they are learned. They are not even waiting for a final learning of all the lessons before applying them because even extending or disseminating the lessons of an experiment is still part of the experiment. The chain of referral or the chain of command is also very well oiled. The other aspect of this is the people's own beliefs about illness and what is permitted and not permitted in terms of their gods, spirits and ancestors. These are all taken into consideration far more sensibly than has happened in very many programmes that I have seen. Finally and most importantly service delivery is not time bound in terms of service. People are not told to come at eight o'clock in morning and be seen but people are seen when they have a need to be seen. A woman may be cooking but if she feels like going to see the nurse midwife at that time she goes and sees the nurse.

Let me single out one activity that I think is so very important and that is the Community Health Midwife concept. If there is any staff person in community health particularly with respect to reproductive health and FP that should be supported and trained well and supervised well and remunerated well it is the Community Health Midwife —Trained Midwife as against the Traditional Midwife. Trained Midwife is critical to the success of reproductive health particularly the Safe Motherhood programme because this is the sort of person who will be able to handle ordinary deliveries as and when they occur, where they occur or very close to where they occur. They will also be the ones to know signs, disturbing signs and identify them quickly. If they are supported with simple equipment such as a Motorola or cell phone system to call a base for transport in case of emergency, great results would be achieved provided that the emergency station is well equipped and well manned. But Navrongo has emphasised these and it has shown how to bring people into or involve them in their own health care delivery at reasonable cost and this has been documented.

Are there any activities or policies that can best focus on the problems of maternal mortality, female genital mutilation (FGM), STDs, and HIV prevention for instance?

You want us to write a book! Well the first one is to have a reproductive health policy in which these things are

identified. Such a policy should have a general developmental aspect and these specifics which are the ones being asked for. I have already talked about the general developmental aspects. Every girl should be educated at least seven years of in-school education, preferably more. Every woman, if she chooses to work, should be assisted to be gainfully employed. Gender violence for instance should be taken care of so that women feel confident in themselves. Specific activities should ensure that women have children only when they want to have children. Women should know children do not have to come by accident. The services that should let women attain this kind of consciousness about when to have children and when not to have children should be provided as close to the women as possible and also made affordable. Alongside these services should be education on sexually transmitted diseases and their prevention accompanied by services for early diagnoses and treatment. For HIV/AIDS we know we still have got abstinence, fidelity in marriage and condom use as the only real approaches in our system. Then when we come to maternal mortality specifically we have got the approaches which can be community-based with trained personnel with back-up services. Community-based approaches means we should educate ourselves about what belief systems the people in the community have regarding pregnancy, what it takes for a pregnancy to come to term, childbirth and so on, and educate ourselves as to what the true situations are. I keep talking about the community because delays that cause maternal mortality start from there—delay in appreciating that something is wrong. In some of our communities a woman cannot go to the hospital by herself, a man has to be there. A pregnant woman has to seek her husband's permission to attend hospital. If the husband is not there what happens? So these are the things that we have to disabuse the minds of the community about.

Is it all then about attitudinal change?

Attitudes have to change for us to move forward but the system also has to be streamlined. We have to think in terms of a two-way transport and communication system from the community to the centre or to the backup

Education both formal and informal is key to eradicating the practice of FGM.



Adolescent girls learn livelihood skills

service and vice-versa. Right here in Ghana some communities have arranged with private transport drivers so that when a card is shown a driver takes the woman to the nearest hospital or clinic for assistance without charging any fee—the fee will be dealt with later because this has been negotiated. We are therefore thinking of how you get care inside the community; identify the emergency as it happens, make arrangements for communication by cell phone or telephone, make arrangements for transportation and then see to it that there are trained physicians or trained assistants at the facilities which serve as the back-up system to receive such cases and deal with them because we think in obstetrics or in safe motherhood the deaths can occur very rapidly without your having any notice. So transportation to a point where service can be given is very, very important. The equipment and trained personnel at the facility is crucial. There must be an adequate supply of antibiotics, transfusion fluids or even blood if possible.

Another area in which our women are dying is from the after effects of unsafe abortion. In some countries 30% of women who die from pregnancy-related causes are dying from unsafe abortion. There are laws covering abortion, some of these laws need to be looked at but whatever happens doctors need to be trained and equipped to handle unsafe abortion without being judgmental. We are not custodians of society's morality; we are custodians of society's health. We have to be moral, we may pass judgment sometimes but we shouldn't judge people when they need our services and so we have to train our doctors to handle any situation including infections, bleeding, retained products and so on. And when we have a comprehensive policy of handling sexually transmitted diseases, we should make this known and seek all possible help—train husbands and community members generally to recognize this need.

How about FGM, are there any specific policies to address it?

FGM again relates to education and relates to the legal situation, but mainly education. This country has had a

law since 1994 criminalizing FGM but some are running to the neighbouring countries to get it done, others are doing it quietly in their homes. If there are no side effects or complications people do not get to know. So education is the number one issue here. In terms of the law both those who cut and those who do the cutting should be made to know the law. In some countries what has happened is that the women who do the cutting are assisted to have another source of income—a more decent way of making a living—since this is part of their source of livelihood. When they are given another source of livelihood then they are recruited into those who educate both the client and the public. In addition to our laws we should start thinking along those lines. Identify the people who do the cutting and get them to do other things that are more profitable.

Volume 2, Number 29, 2002

WHO'S BEHIND THE SCENES?

Dr. James F. Phillips of the Population Council has played an inconspicuous yet important part in the development of the CHFP and CHPS. He discusses his work.

You are an American, but you always seem to be in Navrongo. What brings you this way all the time?



Jim Phillips—Behind the scenes, but in the centre of things!

I first came to Navrongo in 1991. Professor Fred Sai contacted Professor George Benneh and they invited me to visit Ghana to lecture on work that we were doing in Bangladesh. Prof. Sai was very familiar with the success of the Matlab project in Bangladesh and he thought that this experimental study and its use by the Government of Bangladesh would be relevant to his own country. In the course of my brief stay, I met Dr. Moses Adibo who was then Director General of the MOH and Dr. Sam Adjei who was then head of the Health Research Unit. Both of them told me to go to Navrongo. I went, not really knowing why. I thought that Navrongo was somewhere around Kumasi. The road was terrible, and I arrived at 1:00 AM. No one in Navrongo knew why I was coming, and I was not totally sure why I was there. But, I soon learned that the Vitamin A Supplementation Trial was ending and that Fred Binka had a mandate to convert the project into a research centre. Fred talked my ear off, and we have been working together ever since.

What was the Matlab project and how did it influence what you eventually decided to do in Ghana?

Matlab was a project that responded to the health policy debate with research. Once results were in, this evidence was used to change the national health programme. Ghana also had a debate under way. The subject of debate was different, but it seemed to me that resources for research in Ghana would be resources well spent.

What do Bangladesh and Ghana, Matlab and Navrongo, have in common?

Skeptics said that nothing could work in rural Bangladesh. Fertility, in particular would be high even if FP services were accessible. When Matlab started, the Bangladeshis' involvement soon proved that skeptics were wrong. Many said FP would never work. But it did.

What sets Navrongo and Matlab apart?

Navrongo bases its services system on social institutions. In the villages, everything is either community run or carefully worked out with traditional leaders. Matlab was different. It was run as an organization that is somewhat separate from communities. Many successful



What does this have to do with Navrongo?

programmes in Bangladesh work that way—as top-down operations. This method would fail in Ghana. The Matlab experimental approach worked in Navrongo, not because the two studies were so similar, but because the approaches were different.

Ten years down the road, what is there to show that resources have been well spent?

The main thing that will endure is the success of the CHPS. Navrongo is spreading across the country, and beyond.

What if the experiment did not work?

The experiment was designed to answer questions. A scientifically designed trial can never fail if it answers questions.

People say Navrongo has a unique role to play in CHPS. What do you say?

CHPS would lose its rudder if it were not for Navrongo and places like Nkwanta where the model is clear, communication is sound, and demonstration is continuous.

***What works?*... notes have been conceived to guide districts in Ghana implementing CHPS, but evidence suggests that they are serving other purposes, how do you react to that?**

They are spreading on the World Wide Web like computer viruses!

The notes contain valuable information, are you satisfied with the packaging?

I like the CD-ROM version with built in video clips.

You have made 47 round trips to Navrongo. The roads are certainly not as bad as they once were. But what has changed in Kassena-Nankana that can be attributed to the CHFP?

Health has improved. Men have become major partners in the promotion FP. I would not have predicted that.

Can you give us some facts and figures?

Papers of the NHRC show that fertility in the first three years was reduced by one birth; childhood mortality was reduced by over a third. Neonatal mortality remains tragically high. I hope that research would turn to this important problem.

We are at the beginning of the end of the CHFP.

What are the matters arising?

What you have now is the end of the beginning not the beginning of the end. The new beginning will have to work on critical issues such as adolescent health and emergency obstetric care. There will be scaling up of the intensive service cell and examination of the impact of removing operational variance. But mainly *What works?* will go on for years.

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LOOKING BEYOND WHAT WORKS

Dr. Abraham Hodgson, Director of the NHRC, discusses his work.

A lot of districts have tried to replicate the CHFP, some have been more successful than others. What does it take to successfully replicate the CHFP?

Some have been able to understand better what the CHFP experiment set out to address and the methods used. They have subsequently been able to analyze their own situation and adapted the CHFP methodology to it.

The NHRC has also facilitated the work of others by giving them practical onsite orientation of the experiment so as to enable them successfully replicate it. Of course, those who were in doubt always came back to seek technical assistance. Nkwanta District has been here many times and I have now lost count of the number of times Juabeso Bia District has sent teams here for orientation! Monitoring results from the Policy Planning, Monitoring and Evaluation Division of the GHS clearly show that these two districts are among the most successful in the implementation of the Community based Health Planning and Services (CHPS) initiative in the country.

What exactly does Navrongo do to orientate districts to the CHPS process?

Two main things: One, by providing practical onsite training to districts that visit Navrongo and two, following up to districts to see what difficulties they encounter in the process of putting what works to work. When districts visit Navrongo they are usually taken through a few hours of presentations on the activities of the Centre generally, before zeroing in on the CHFP. They are then taken out into the field where they spend a week or two with the resident nurse to get a practical feel of how the system works. The nurse takes them out on compound visits so that they see service delivery in

Dr. Abraham Hodgson, MB ChB, MPH, PHD, is Director of the Navrongo Health Research Centre.



Looking beyond what works to making what works work for others

real practice. No one comes to Navrongo for practical orientation to CHPS and leaves without the conviction and resolve that they too can do it in their communities. The second thing Navrongo does it to go on follow up visits to district to see how they are rolling out the programme and provide situational technical support. These two main activities have turned out to be exceedingly rewarding even for Navrongo as there has been a great deal of cross fertilization of ideas to improve the process.

The *What works? What fails?* series has been developed to guide districts in the replication of the CHFP. Do you think these notes have been useful at all to the districts?

Usually after an experiment like this generates results, project reports are written which are often too bulky or laced with too many jargons to be of interest to people other than the scientific community. But scientific information is not meant for scientists alone—there are the ordinary people who want to have access to the information and use it. *What works? What fails?* was developed to address the need to break scientific information down into simple-to-read formats. Ordinary people want to know what works and what fails and this is the need that the series addresses. The notes are in great demand and we have had to reprint them over and over again to meet the rising demand. This demand is even set to increase over the next few years as the country's development partners make commitments to assist the country implement the programme on a countrywide scale. But I have recently been concerned though, that the notes may not be getting to all the districts as regularly as they should and I have asked that our mailing strategies and distribution system be reviewed.

How did you engage communities in this? Were community members really involved in the experiment? As a field based study we knew right from the outset that if we did not engage the communities in the experiment we had already failed even before we have started. We approached the chiefs and their people and they served as project consultants. We laid the issues before them



A district public health nurse from Juabeso Bia in Navrongo to study how the system works

making them understand that we had a common goal of improving the health of the people and that together we could find the most effective solutions. Thereafter the communities selected people to be trained as health volunteers who went back to assist in health care delivery. The community also received the resident nurse with open arms and, through communal labour, provided accommodation for her. They also ensured her safety and comfort but above all, they patronized the services that were now at their doorstep. Ongoing dialogue kept conflict at bay and ensured that problems did not arise to disrupt the experiment. This has been a very effective way of mobilising communities and getting them involved in delivering health care.

Are there any plans to spread the CHFP across the country's borders?

Yes indeed. The results of the experiment cannot be confined within the country's borders alone. We owe it a duty to humanity to make the results of our experiment readily available to other countries. We have begun to set the broad outlines for a meeting with policy makers of some neighbouring countries. We intend to present findings of the experiment and encourage them to try out the Navrongo-like service delivery model. With time we should be able to visit them to see how they are adapting Navrongo to their settings. I should add that

the '*What works...*' has already gone international—notes have been posted on the Navrongo website at www.navrongo.org or on the CHPS site at www.ghana-chps.org. Besides, electronic copies are mailed to over 280 recipients worldwide.

What are your next steps in the development of the “*What works...*” series?

The main aim of the series was to build consensus that the CHFP can be replicated. This has largely been achieved. The complete works of the series is being compiled and bound into one single volume. But we are looking beyond that, especially so, as people begin to ask for practical steps to replicate the process. So right away we are talking about a toolkit—an implementation manual. People need ready-to-use information on, for instance, how to enter a community

and engage the people in discussions about improving health; how to build consensus for building a nurse's compound; how to determine the location of a compound without any controversy; and how to choose volunteers and what scope of work they should be assigned. These are some of the issues that the implementation manual would address. We are also producing video clips on the implementation milestones to guide those who want to launch the programme but are not able to visit Navrongo before they start. We are currently experimenting with producing CD-ROM versions of the '*What works...*' notes with embedded video clips. We hope that we can find partners who would support us speed up these processes so that many more people can benefit from the project.